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Research Article

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Association of nurses' knowledge and motivation with spiritual care provision for critically ill patients: a cross-sectional study

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Abstract

Spiritual care is an important component of holistic care for critically ill patients, yet nurses may encounter difficulties integrating it into clinical practice. This study examined the associations of nurses' knowledge and motivation with spiritual care provision for critically ill patients at H. A. Sulthan Daeng Radja Bulukumba Regional Public Hospital. A descriptive correlational study with a cross-sectional design was conducted among 60 eligible nurses working in the Intensive Care Unit (ICU) and Emergency Department (ED), recruited using total sampling. Data were collected using study-specific questionnaires measuring knowledge, motivation, and self-reported spiritual care provision. Fisher's exact test showed significant associations between knowledge and spiritual care provision (p = 0.018; OR = 4.69; 95% CI: 1.39–15.87) and between motivation and spiritual care provision (p = 0.012; OR = 10.73; 95% CI: 2.82–40.77). Nurses with good knowledge and strong motivation were more likely to report good spiritual care provision. Educational and institutional support may strengthen spiritual care practices, although further longitudinal or interventional studies are needed.

INTRODUCTION

Spiritual care is an integral component of holistic nursing for people facing serious or life-threatening illness. In addition to severe physiological problems, critically ill patients may experience anxiety, helplessness, loss of meaning, uncertainty, and fear of death. These experiences may generate spiritual needs that require attention as part of patient-centered care [1,2,3]. International evidence and consensus recommendations support integrating spiritual care into care for patients with serious illness and preparing healthcare professionals to address these needs [4].

Spiritual needs may nevertheless remain insufficiently assessed or addressed in high-acuity settings. In the ICU and ED, immediate attention is commonly directed toward physiological stabilization and life-saving interventions. Nurses may also face limited time, high workloads, emotional strain, insufficient education, lack of confidence, and limited organizational

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support [5,6,7] . Reviews of critical care practice have identified personal, organizational, and team-related barriers, while preparation, communication, collaboration, and access to spiritual care providers may facilitate spiritual care [3, 7].

The issue is relevant in Indonesia, where spiritual and religious practices may be important sources of meaning, hope, and coping for patients and families. A recent Indonesian survey found that nurses generally held positive perceptions of spirituality and spiritual care but reported providing spiritual care only occasionally [8]. Spiritual care should not, however, be based on assumptions about a patient's religion. It should be individualized, culturally sensitive, and guided by the patient's expressed beliefs, values, and preferences [9].

The conceptual basis of this study is that critical illness may create existential distress and spiritual needs, requiring a holistic nursing response. Knowledge may help nurses recognize spiritual distress, conduct spiritual assessment, communicate sensitively, and identify appropriate interventions. Motivation may influence whether nurses apply this knowledge while managing competing clinical priorities. Evidence from Indonesia has also suggested positive relationships between knowledge and motivation and spiritual care competence among ICU nurses, although available studies remain limited in scale and setting [10].

Despite growing international literature, evidence remains limited regarding whether nurses' knowledge and motivation are associated with spiritual care provision in Indonesian regional hospitals, where training opportunities and dedicated spiritual care resources may be constrained. ICU and ED nurses both care for critically ill patients, although they work under different clinical pressures. This study aimed to examine the associations of nurses' knowledge and motivation with spiritual care provision for critically ill patients at H. A. Sulthan Daeng Radja Bulukumba Regional Public Hospital.

METHODS

Study Design and Setting

This quantitative study used a descriptive correlational, cross-sectional design to examine associations among variables measured at a single point in time without establishing causality [11] Data were collected at H. A. Sulthan Daeng Radja Bulukumba Regional Public Hospital from June to August 2024.

Participants and Sampling

The study population consisted of all nurses working in the ICU and ED during the study period. These units were selected because their nurses routinely provide care to critically ill patients. ED nurses were included because they frequently provide initial stabilization and critical care to patients with life-threatening conditions before ICU admission. We used a total sampling approach to recruit all nurses in both units who met the eligibility criteria. All 60 eligible nurses were invited and participated in the study; therefore, the final sample size reflected the accessible eligible population in the two units rather than a sample size formula or random selection procedure.

The inclusion criteria were registered nurses working in the ICU or ED, having at least six months of clinical experience in the respective unit, and providing written informed consent. Nurses who were on leave or sick leave during data collection were not available for recruitment. Questionnaires with incomplete responses were excluded from analysis. The independent variables were knowledge and motivation, and the dependent variable was self-reported spiritual care provision.

Instrument Development and Validation

Three members of the research team developed the three questionnaires for this study through a review of relevant spiritual care literature, consensus recommendations, and existing spiritual care instruments. The principal sources included Balboni et al. [4], Mamier and Taylor [12], Puchalski et al. [9] Taylor [13], Tiew et al. [14], and van Leeuwen et al. [15]. These sources informed the conceptual definitions and content domains related to spirituality in serious illness, holistic and patient-centered care, spiritual assessment, nursing interventions, therapeutic communication, referral, collaboration, professional responsibility, and the frequency of nurse-provided spiritual care.

The source instruments were not translated or reproduced in their complete original forms. Instead, the research team identified relevant concepts and domains, drafted study-specific items, and modified their content and wording to correspond with the study objectives and the context of Indonesian ICU and ED nurses. English-language concepts and statements used during item development were translated into Indonesian by a bilingual person proficient in Indonesian and English. The Indonesian wording was then refined for clarity and contextual relevance. A formal back-translation procedure was not conducted. The research team developed the knowledge and motivation questionnaires. The spiritual care provision questionnaire was informed particularly by the practice-oriented concepts of the Nurse Spiritual Care Therapeutics Scale [12] and selected domains of the Spiritual Care Competence Scale [15]. Because the final questionnaires differed from the referenced instruments in their constructs, item composition, response formats, and scoring procedures, they were treated as study-specific instruments rather than translated or validated Indonesian versions of the original instruments.

Three nursing academics with expertise in spiritual care reviewed the draft questionnaires for relevance, clarity, and contextual appropriateness. The questionnaires were subsequently pilot-tested among 30 nurses who were not included in the main study. Item-total correlations were examined during pilot testing, and items with coefficients exceeding the predetermined critical value of 0.361 were retained. Internal consistency was assessed using Cronbach's alpha, yielding coefficients of 0.78 for the knowledge questionnaire, 0.82 for the motivation questionnaire, and 0.85 for the spiritual care provision questionnaire.

Questionnaire Content and Scoring

The knowledge questionnaire contained 15 multiple-choice items covering spiritual care concepts, spiritual distress, spiritual assessment, nursing interventions, family involvement, barriers, and holistic nursing care. Correct answers were scored 1 and incorrect answers 0, yielding a total score of 0–15. Knowledge was classified as good for scores of 12–15, adequate for scores of 9–11, and poor for scores of 0–8. Only the good and adequate categories were represented in the study sample.

The motivation questionnaire contained 10 items assessing intrinsic and extrinsic motivation. Items were rated from 1 (strongly disagree) to 4 (strongly agree), yielding a total score of 10–40. Scores of 30–40 indicated strong motivation, 20–29 moderate motivation, and 10–19 low motivation. Only the strong and moderate categories were represented in the study sample.

The spiritual care provision questionnaire contained 15 items covering spiritual assessment, nursing interventions, family involvement, collaboration and referral, documentation, and evaluation. Items were rated from 1 (never) to 4 (always), yielding a total score of 15–60. The original scoring

framework classified spiritual care provision as poor (15–29), adequate (30–44), or good (45–60). For the bivariate analysis, the poor and adequate categories were combined as inadequate spiritual care provision (15–44) to create a binary outcome for the planned 2 × 2 association analysis, while scores of 45–60 were classified as good spiritual care provision.

Data Analysis

Data were analyzed using SPSS version 22. Univariate analysis summarized respondent characteristics and study variables. Bivariate associations were examined using Fisher's exact test when the expected-cell assumptions of the chi-square test were not satisfied. Unadjusted odds ratios (ORs) with 95% confidence intervals (CIs) were calculated. Statistical significance was set at $p < 0.05$.

Ethical Considerations

Ethical approval was granted by the Ethical Committee of Panrita Husada Bulukumba School of Health Sciences (No. 001435/KEP Stikes Panrita Husada Bulukumba/2024). Participants received information about the study and provided written informed consent.

RESULTS

The study included 60 nurses. Most respondents were female (63.3%), aged 20–44 years (95.0%), married (85.0%), and had completed a professional nursing program (55.0%). Forty-one respondents (68.3%) had at least three years of clinical experience. Thirty-nine respondents (65.0%) worked in the ED and 21 (35.0%) in the ICU (Table 1).

Fisher's exact test showed a statistically significant association between nurses' knowledge and self-reported spiritual care provision ($p = 0.018$). Nurses with good knowledge had higher odds of reporting good spiritual care provision than those with adequate knowledge (OR = 4.69; 95% CI: 1.39–15.87). Motivation was also significantly associated with self-reported spiritual care provision ($p = 0.012$). Nurses with strong motivation had higher odds of reporting good spiritual care provision than those with moderate motivation (OR = 10.73; 95% CI: 2.82–40.77). The wide confidence interval for motivation indicates uncertainty regarding the precise magnitude of this association.

Table 1
Characteristics of respondents (n = 60)

Characteristic	n	%
Sex		
Male	22	36.7
Female	38	63.3
Age (years)		
20–44	57	95.0
45–64	3	5.0
Marital status		
Married	51	85.0
Unmarried	9	15.0
Education		
Diploma III	27	45.0
Professional nursing program	33	55.0
Work experience		
<3 years	19	31.7
≥3 years	41	68.3
Clinical unit		
Emergency Department	39	65.0
Intensive Care Unit	21	35.0

Table 2
Associations of nurses' knowledge and motivation with spiritual care provision (n = 60)

Variable	Good provision, n (%)	Inadequate provision, n (%)	Total, n (%)	OR (95% CI)	p-value
Knowledge: Good	31 (83.8)	6 (16.2)	37 (100.0)	4.69 (1.39–15.87)	0.018
Knowledge: Adequate	12 (52.2)	11 (47.8)	23 (100.0)	Reference	
Motivation: Strong	33 (89.2)	4 (10.8)	37 (100.0)	10.73 (2.82–40.77)	0.012
Motivation: Moderate	10 (43.5)	13 (56.5)	23 (100.0)	Reference	
Total	43 (71.7)	17 (28.3)	60 (100.0)		

Note: OR = odds ratio; CI = confidence interval. Percentages are calculated within each knowledge or motivation category. Adequate knowledge and moderate motivation were the reference categories. P-values were obtained using Fisher's exact test.

DISCUSSION

Nurses' Knowledge and Spiritual Care Provision

This study found that nurses with good knowledge had higher odds of reporting good spiritual care provision than nurses with adequate knowledge. Knowledge may provide the cognitive foundation needed to recognize spiritual distress, assess spiritual needs, communicate sensitively, and select appropriate responses. Spiritual needs may be communicated indirectly through fear, hopelessness, loss of meaning, uncertainty, or concerns about death [1,2,3].

Knowledge should extend beyond familiarity with religious practices and include spiritual assessment, therapeutic communication, ethical sensitivity, collaboration, referral, documentation, and respect for diverse beliefs [9,13,15] The finding is consistent with Indonesian evidence linking nurses' perceptions of spirituality with spiritual care practices [8] and with broader evidence identifying education and work environment as factors associated with spiritual care competence [16]. Differences in design and measurement should nevertheless be considered because those studies assessed perceptions or competence rather than the study-specific outcome used here.

The ICU and ED contexts also warrant consideration. ED nurses work within rapid triage and stabilization processes. In contrast, ICU nurses may have longer contact with patients and families while managing complex technology, uncertain prognoses, and end-of-life situations [7,17] . This study did not directly examine these contextual differences because it did not statistically compare spiritual care provision between the two units.

Nurses' Motivation and Spiritual Care Provision

Nurses with strong motivation had higher odds of reporting good spiritual care provision than those with moderate motivation. Motivation may matter because knowledge alone does not ensure spiritual care is incorporated into daily nursing practice. Nurses must decide whether to initiate sensitive conversations, allocate time for assessment, involve families, document spiritual concerns, or arrange referrals while managing competing clinical priorities.

Intrinsic motivation may involve professional responsibility, personal commitment, and satisfaction in meeting patients' needs. In contrast, extrinsic motivation may be supported by leadership, training opportunities, clear guidance, and institutional recognition of spiritual care. An Indonesian ICU study similarly reported positive correlations of knowledge and motivation with spiritual care competence, although its smaller sample and different

measurement approach limit direct comparison [10]. Reviews also indicate that organizational conditions, education, and working environment are associated with spiritual care competence and practice [7;16].

Spirituality and religion may be important sources of meaning and coping for many Indonesian patients and families, but nurses should not assume shared beliefs. Spiritual care should be patient-centered and based on individual assessment. Depending on patient preferences, support may involve attentive listening, quiet presence, prayer, family participation, access to religious resources, or referral to an appropriate spiritual care provider [3,9].

The relatively high OR for motivation should be interpreted cautiously. Its wide 95% CI indicates limited precision, likely related to the modest sample size and small cell counts. The result represents an unadjusted association and does not demonstrate that motivation directly causes better spiritual care provision.

Implications for Nursing Practice and Hospital Management

Hospitals may consider structured spiritual care education for ICU and ED nurses, including spiritual distress, brief assessment, communication, culturally sensitive care, family engagement, documentation, referral, and ethical boundaries. Previous interventional research has reported improved spiritual care competency following structured education, although the effectiveness of any program in the study setting would require prospective evaluation [18].

Brief spiritual assessment prompts could also be explored within nursing assessment and documentation. Hospitals may consider referral and collaboration pathways involving nurses, physicians, families, spiritual care providers, and religious or community leaders when the patient requests them. Reflective practice or clinical supervision may help nurses process the emotional demands of caring for critically ill or dying patients, but these approaches were not evaluated in the present study [6,7].

Limitations

This study had several limitations. First, the relatively small sample from one regional hospital limits the generalizability and precision of the findings. Second, the cross-sectional design did not establish temporal sequence or causality. Third, the study relied on self-reported questionnaires, which may have been affected by social desirability and may not fully reflect observed clinical practice.

Fourth, the analysis was limited to bivariate associations. The reported ORs were unadjusted for potential confounders such as age, education, clinical unit, and work experience. Other potentially relevant factors, including workload, nurse-to-patient ratio, previous spiritual care training, institutional support, and personal spiritual or religious orientation, were not comprehensively controlled. We analyzed ICU and ED nurses together despite possible workflow differences.

Finally, the questionnaires were developed specifically for this study and did not undergo full cross-cultural adaptation or construct-validation. Although expert review, pilot testing, item-total analysis, and internal-consistency assessment were conducted, further psychometric evaluation is needed. Future research should include larger multicenter samples, observational measures of spiritual care, and multivariable, longitudinal, or interventional designs.

CONCLUSION

Higher levels of nurses' knowledge and motivation were significantly associated with better self-reported spiritual care provision for critically ill patients. Nurses with good knowledge and strong motivation had higher odds of reporting good spiritual care provision than those with adequate knowledge and moderate motivation, respectively. These unadjusted associations should not be interpreted as evidence that knowledge or motivation directly causes better spiritual care provision. Healthcare institutions may consider structured education, clinical guidance, reflective supervision, and organizational support to facilitate spiritual care practices. Larger multicenter studies using multivariable, longitudinal, or interventional designs are needed to obtain more precise estimates, account for potential confounding factors, and clarify the direction of these associations.

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Tabel 2
Instrumen Literasi Kesehatan Ginjal pada Remaja Versi Bahasa Indonesia

No	Pertanyaan
	Kemajuan Diri
1	Saya berusaha mendapatkan informasi tentang cara menjaga kesehatan ginjal dari internet, media sosial, atau buku.
2	Saya mampu menemukan informasi lebih lanjut tentang kesehatan ginjal
3	Ketika saya ingin mengetahui tentang penyakit ginjal kronik atau cara pencegahannya, saya dapat memperoleh informasi yang saya butuhkan.
4	Saya mampu bertanya kepada orang lain mengenai informasi tentang penyakit ginjal kronik
	Kemampuan Mengakses / Memperoleh Informasi Kesehatan
5	Saya mampu mengakses informasi tentang makanan dan minuman yang baik untuk kesehatan ginjal.
6	Saya mampu mengakses informasi tentang olahraga atau aktivitas fisik yang baik untuk mencegah penyakit ginjal kronik.
7	Saya mampu mengakses informasi tentang cara perawatan yang tepat agar ginjal tetap sehat
8	Saya mampu mengakses informasi kesehatan tentang menjaga kesehatan ginjal sejak remaja
9	Saya mampu menemukan sumber informasi kesehatan ginjal di internet
	Kemampuan membaca
10	Saya dapat membaca brosur atau informasi tertulis tentang obat yang diresepkan untuk pencegahan atau pengelolaan penyakit ginjal kronik.
11	Saya dapat membaca brosur pendidikan kesehatan tentang masalah penyakit ginjal kronik
12	Saya dapat membaca brosur tentang pencegahan penyakit ginjal kronik
13	Saya dapat membaca informasi kesehatan ginjal di majalah atau koran.
14	Saya dapat membaca materi informasi kesehatan ginjal di internet atau situs web yang resmi.
	Kemampuan memahami informasi ksehatan
15	Saya dapat memahami tanda dan gejala penyakit ginjal kronik
16	Saya dapat memahami sebagian besar informasi yang saya dengar mengenai pencegahan penyakit ginjal kronik
17	Saya dapat memahami isi informasi kesehatan yang saya temukan terkait pencegahan penyakit ginjal kronik
18	Saya dapat memahami instruksi dan rekomendasi dokter untuk pencegahan penyakit ginjal kronik.
19	Saya dapat memahami informasi tentang obat-obatan, termasuk cara penggunaan, efek samping, dan peringatan, untuk menjaga ginjal tetap sehat
20	Saya dapat memahami informasi nutrisi pada kemasan makanan dan minuman olahan untuk memilih makanan yang baik untuk kesehatan ginjal.
21	Saya dapat memahami informasi dan rekomendasi dari media (misalnya radio, TV, internet, dll.) mengenai gizi yang tepat untuk menjaga kesehatan ginjal remaja
22	Saya dapat memahami informasi dan peringatan dari media (misalnya radio, TV, internet) tentang perilaku yang berisiko bagi kesehatan ginjal seperti es teh, boba, minuman berperwarna, berpengawet, minuman kemasan dan makanan yang berlemak
23	Saya dapat memahami informasi dan rekomendasi tentang kesehatan ginjal dan penyakit ginjal kronik di media
24	Saya dapat memahami rekomendasi tentang pencegahan penyakit ginjal kronik
	Kemampuan menilai/menafsirkan informasi kesehatan
25	Saya dapat menilai apakah informasi tentang kesehatan ginjal yang saya dapatkan benar atau tidak.
26	Saya akan membandingkan informasi yang benar dan salah tentang penyakit ginjal kronik.
27	Ketika saya menghadapi informasi yang berbeda atau bertentangan tentang penyakit ginjal kronik, saya dapat mengenali informasi yang benar dan dapat dipercaya
28	Saya memiliki kemampuan untuk menilai sumber informasi tentang penyakit ginjal kronik mana yang dapat saya percayai.
29	Ketika menghadapi informasi mengenai gizi yang berkaitan dengan kesehatan ginjal, saya dapat memilih informasi yang tepat dan sesuai.
	Kemampuan menggunakan informasi dalam pengambilan keputusan
30	Ketika membeli makanan dan minuman, saya memilih makanan dan minuman yang mendukung kesehatan ginjal berdasarkan informasi nutrisi pada kemasannya (misalnya jumlah energi, gula, garam, protein, dan lemak)
31	Saya berusaha memilih makanan dan minuman yang bebas dari bahan pengawet untuk menjaga kesehatan ginjal saya.
32	Saya berusaha menerapkan pengetahuan tentang pencegahan penyakit ginjal kronik dalam kehidupan sehari-hari
33	Saya berusaha menjaga kesehatan tubuh dengan gaya hidup sehat sebagai bagian dari upaya pencegahan penyakit ginjal kronik.

No	Pertanyaan
	Kemampuan komunikasi
34	Saya dapat mendiskusikan kekhawatiran atau pertanyaan saya tentang pencegahan penyakit ginjal kronik dengan orang lain
35	Ketika datang ke pelayanan kesehatan, saya dapat menyampaikan informasi terkait pencegahan penyakit ginjal kronik
36	Ketika datang ke pelayanan kesehatan, saya dapat memberi tahu nama obat-obatan yang pernah saya gunakan sebelumnya terkait dengan penyakit ginjal kronik
37	Saya dapat menanyakan semua pertanyaan yang saya miliki terkait penyakit ginjal kronik ketika datang ke pelayanan kesehatan,
38	Saya dapat berbagi informasi tentang kesehatan ginjal yang saya peroleh dengan teman atau keluarga.
39	Jika saya memiliki pertanyaan tentang masalah kesehatan ginjal kronik, saya bisa mendapatkan informasi dan saran dari orang lain
40	saya dapat mengajukan pertanyaan mengenai penyakit ginjal kronik berdasarkan informasi yang diperoleh ketika datang ke pelayanan kesehatan,
41	Saya berbicara dengan teman-teman tentang cara menghindari perilaku yang berisiko bagi kesehatan ginjal, seperti es teh, boba, minuman berperwarna, berpengawet dan makanan yang berlemak

Tabel 3
Nilai Uji Korelasi Setiap Butir Pertanyaan Instrumen Literasi Kesehatan Ginjal Pada Remaja Versi Bahasa Indonesia

Kode Pertanyaan	r-tabel	r-hitung	keterangan	*Cronbach's Alpha*
P1	0.361	0.649	valid	
P2	0.361	0.596	valid	
P3	0.361	0.529	valid	
P4	0.361	0.564	valid	
P5	0.361	0.489	valid	
P6	0.361	0.557	valid	
P7	0.361	0.556	valid	
P8	0.361	0.504	valid	
P9	0.361	0.630	valid	
P10	0.361	0.519	valid	
P11	0.361	0.517	valid	
P12	0.361	0.566	valid	
P13	0.361	0.598	valid	
P14	0.361	0.675	valid	
P15	0.361	0.784	valid	
P16	0.361	0.792	valid	
P17	0.361	0.771	valid	
P18	0.361	0.508	valid	
P19	0.361	0.762	valid	
P20	0.361	0.561	valid	0.966
P21	0.361	0.510	valid	(Sangat
P22	0.361	0.527	valid	Reliabel)
P23	0.361	0.683	valid	
P24	0.361	0.668	valid	
P25	0.361	0.819	valid	
P26	0.361	0.772	valid	
P27	0.361	0.859	valid	
P28	0.361	0.768	valid	
P29	0.361	0.748	valid	
P30	0.361	0.552	valid	
P31	0.361	0.487	valid	
P32	0.361	0.645	valid	
P33	0.361	0.513	valid	
P34	0.361	0.820	valid	
P35	0.361	0.767	valid	
P36	0.361	0.481	valid	
P37	0.361	0.653	valid	
P38	0.361	0.702	valid	
P39	0.361	0.710	valid	
P40	0.361	0.580	valid	
P41	0.361	0.716	valid	