

Spiritual Well-Being and Nursing Care Perceptions of Coronary Intensive Care Patients

Koroner Yoğun Bakım Hastalarının Spiritüel İyilik ve Hemşirelik Bakımı Algıları

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ABSTRACT

Objective: The aim of this study was to determine the relationship between the spiritual well-being of patients in coronary intensive care unit and their perception of nursing care as well as the factors affecting their spiritual well-being.

Methods: This study was carried out in descriptive design. 113 patients hospitalized in coronary intensive care unit were included in the study. Data were collected using Patient Information Form, the Patient Perception of Nursing Care Scale (PPNCS), and the Spiritual Well-being Scale (SWS). Mann-Whitney U test and Spearman correlation analysis were used for statistical analysis.

Results: The points obtained by the patients in the scales were determined as SWS mean total points of (96.80 ± 11.61) and PPNCS mean total points of (18.76 ± 13.37). A difference was determined between the age of the patients, the number of admissions to intensive care units, the length of stay in intensive care units, and the SWS ($P < .05$). A statistically significant weak negative correlation was found between the PPNCS and the SWB ($r = -.348$; $p < .001$).

Conclusion: It was determined that the patients' spiritual well-being levels were high and their nursing care perceptions were low. It was determined that as the perception of nursing care of the patients increased, their spiritual well-being decreased. Nurses can improve the quality of care by taking into account the spiritual needs of patients.

Keywords: Coronary intensive care, nursing care, spiritual well-being

ÖZ

Amaç: 'Koroner yoğun bakım ünitesinde yatan hastaların ruhsal iyilik halleri ile hemşirelik bakım algıları arasındaki ilişkiyi ve ruhsal iyilik hallerini etkileyen faktörleri belirlemektir.

Yöntemler: Bu çalışma tanımlayıcı desende yapılmıştır. Çalışmaya koroner yoğun bakımda yatan 113 hasta dahil edilmiştir. İstatistiksel analizde Mann-Whitney U testi ve Spearman korelasyon analizi kullanılmıştır. Veriler hasta bilgi formu, Hastanın Hemşirelik Bakımını Algılayış Ölçeği (HHBAÖ) ve Spiritüel İyi Oluş Ölçeği (SİÖÖ) kullanılarak toplanmıştır.

Bulgular: Hastaların ölçeklerden aldıkları puanlar SİÖÖ ortalama toplam puanı (96,80 ± 11,61) ve HHBAÖ ortalama toplam puanı (18,76 ± 13,37) olarak belirlendi. Hastaların yaşı, yoğun bakıma yatış sayısı, yoğun bakımda kalış süreleri ve SİÖÖ puan ortalamaları arasında farklılık saptandı ($P < ,05$). HHBAÖ ile SİÖÖ ölçeği arasındaki zayıf negatif korelasyon tespit edilmiştir ($r = -,348$; $P < ,001$).

Sonuç: Hastaların spiritüel iyi oluş düzeylerinin yüksek, hemşirelik bakım algılarının ise düşük olduğu belirlenmiştir. Hastaların hemşirelik bakımı algısı arttıkça spiritüel iyi oluşlarının azaldığı saptanmıştır. Hemşireler, hastaların manevi ihtiyaçlarını göz önünde bulundurarak bakımın kalitesini artırabilirler.

Anahtar Kelimeler: Koroner yoğun bakım, hemşirelik bakımı, spiritüel iyi oluş

Received/Geliş Tarihi: 17.10.2022

Accepted/Kabul Tarihi: 28.07.2023

Yayın Tarihi/Publication Date: 25.09.2023

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Cite this article as: Soyulu D, Ceyhan Ö, Tekinsoy Kartın P, Soyulu A. Spiritual well-being and nursing care perceptions of coronary intensive care patients. *J Nursology* 2023;26(3):175-182.



INTRODUCTION

Coronary intensive care units (ICU) are specialized units that treat and care for patients who have significant coronary problems.¹ Intensive care unit patients may experience situations such as unfamiliarity with the surroundings and people, being in a life-threatening condition, having disturbed sleep, being bedridden, not seeing family and friends, undergoing painful interventions, and not being sufficiently informed. Consequently, the spiritual distress occurring with problems such as anxiety, fear, sleeplessness, agitation, delirium, and depression can delay the recovery of the patient.^{2,3}

Heart patients' health deteriorates as a result of severe symptoms (such as shortness of breath and weakness), their addiction increases as a result of functional constraints, and their quality of life decreases.⁴ Many patients with severe coronary heart disease develop anxiety, depressed symptoms, and rage as a result of their condition.⁵ It has been reported that spiritual interventions have a positive effect on cardiac parameters.⁶

Spiritual care given to ICU patients increases the ability of the patient to rediscover the meaning of life and cope with the problems caused by the disease and the crisis of existence.^{2,7} In a study by Narayanasamy and Owens,⁸ it was suggested that spiritual care interventions increased the emotional strength of the patient to cope with the disease and pain and directly or indirectly reduced distress. Therefore, spiritual nursing interventions are seen as an important part of patient care.³

Although the importance of spiritual care is known, developments in the field of health care cause nursing care to be applied with technological methods and spiritual care cannot be put into practice.^{9,10} Previous studies have reported that nurses see spiritual care as a role of religious professionals, and they have not received enough information about spiritual care during nursing training.¹¹⁻¹³ However, the nursing process includes determining the spiritual needs of patients and providing appropriate care in response to these requirements.^{14,15} The American Nurses Association (ANA), International Council of Nurses (ICN), and North American Nursing Diagnosis (NANDA) nursing categorization systems include diagnoses for spirituality concepts such as "spirituality," "spiritual distress," "risk of spiritual distress," and "potential to strengthen the spiritual dimension."^{13,15} It is important for nurses who provide holistic care to patients to enhance their spiritual care practices according to the nursing process.¹³

To be able to give spiritual care, it is necessary for the nurse to make a detailed spiritual evaluation. The areas of spiritual evaluation include general and personal spiritual beliefs, the possibilities of improving health, signs of spiritual distress, religious identity, and religious and spiritual support systems.¹⁶ Integrating spirituality and spiritual care standards into nursing care allows health professionals to have a better understanding of their patients while also improving their abilities to heal, calm, and comfort them.¹⁷ Furthermore, in times of stress and uncertainty, patients might benefit from the moral support of a preacher.¹⁸

Nurses are required to have a professional degree of spiritual understanding in order to detect spiritual needs and apply appropriate therapies, skills, and methods.¹⁵ It has been reported in the literature that spiritual care training courses should be organized to increase the knowledge and abilities of ICU health professionals.¹⁹ To equip students with a holistic care concept during the

nursing education process, spirituality and spiritual care-related weaknesses should be identified, and required measures should be developed by assessing the curriculum in this direction.² At the same time, the nursing process, which is a scientific tool, should be used to integrate spiritual care knowledge and theories into nursing practices.¹⁵

Meeting patients' spiritual needs is an important part of holistic nursing care. Patients who have their spiritual needs fulfilled will have a more favorable perception of nursing care, and their capacity to cope with their sickness, adjust to it, and take care of themselves will improve.¹⁹ The aim of this study was to determine the relationship between coronary intensive care patients' perception of nursing care and their spiritual well-being levels and to thereby increase sensitivity to and awareness of this subject.

Research Questions

1. What is the spirituality level of coronary intensive care patients?
2. What is the nursing care perception of coronary intensive care patients?
3. What is the effect of personal characteristics on the spirituality and nursing care perception?
4. Is there a relationship between spiritual well-being and the nursing care perception?

METHODS

Type of Research

In this study a cross-sectional model used to investigate the relationships between patients' perceptions of nursing care and spiritual well-being.

Study Design and Participants

This descriptive study was conducted in the coronary ICU of a university hospital between May and September 2022. Data were collected by asking questions in the data collection form to patients who were discharged from the ICU and to the patients who received service from the ICU.

During this defined study period, a total of 192 patients were admitted to the ICU, of which 113 met the study criteria. Post hoc G power analysis was carried out in line with the results of this study. The sample size was calculated with effect size $f=2.3637270$, Cronbach's $\alpha=0.05$, total sample size=113, and power $(1 - \beta \text{ error probability})=1.0000000$. The study was completed with a total of 113 subjects. The study was started in May 2022 and completed in September 2022 when the sample size planned in September 2022 was reached.

The patients included in the study were those who were conscious (Glasgow Coma Scale score 15), who agreed to take part in the study, who were 18 years old and over, with coronary artery disease, who stayed in the hospital for at least 72 hours, discharged from ICU, with no psychiatric disease or any health problem which would prevent them answering questions.

Data Collection

The research data were collected in a single face-to-face interview, lasting approximately 15-20 minutes, at a convenient time from the patients who were discharged from the ICU and from the patients who received service from the ICU. Informed consent was obtained from all the study participants. A preliminary interview was conducted with 10 patients who were being treated in the ICU, but the data of these patients were not included in the

analysis. The finalized data collecting form was determined after the preliminary interview.

Data were collected using a patient information form, the Patient Perception Nursing Care Scale (PPNCS), and the Spiritual Well-Being Scale (SWS).

Patient Information Form

The patient information form was developed by the researchers with reference to the relevant literature.^{21,20} The patient information form comprised 13 questions to obtain information about the patient's age, gender, marital status, education level, occupation, income, presence of any chronic disease, history of hospital admission, and if so, in which clinic.

The Patient Perception of Nursing Care Scale (PPNCS)

The PPNCS is used to measure the perception of patients about the nursing care and the level of satisfaction with the care provided. The scale was developed by Dozier et al.²¹ and validity and reliability studies of the Turkish version were made by Çoban and Kaşıkçı.²² The scale consists of 15 items related to nursing care quality, and Likert-type responses are scored to give a total ranging from 15 to 75, with higher points indicating higher patient satisfaction with the nursing care. Cronbach's alpha reliability coefficient of the original scale was determined to be 0.94.²¹ The Cronbach's alpha value for the scale was calculated as 0.997 in this study.

The Spiritual Well-Being Scale (SWS)

This scale was developed for use with adults to determine their understanding and process of living life in personal, social, environmental, and transcendental aspects. The SWS comprises 29 items in 3 subgroups of *conformity with nature*, understanding the need to respect nature and living creatures, *transcendentalism*, the belief that there is a superior sacred power, and *anomie*, the belief that unhappiness in life is formed from the negativity of empty and meaningless feelings.²³ Scoring is made on a Likert-type scale, giving a total ranging from 29 to 145. The transcendental subscale includes items 1, 4, 5, 8, 9, 12, 13, 16, 17, 20, 21, 24, 25, 27, and 29, the conformity with nature subscale includes items 2, 6, 10, 14, 18, 22, and 28, and the anomie subscale includes items 3, 7, 11, 15, 19, 23, and 26. The anomie subscale items are reverse scored. Validity and reliability studies of the scale in Turkish were made by Ekşi and Kardaş.²⁴ The internal consistency values of the sub-dimensions of the scale are Cronbach's alpha = 0.95 for transcendence, Cronbach's alpha = 0.86 for conformity with nature, and Cronbach's alpha = 0.85 for anomie; and Cronbach's alpha = 0.89 for the total of the scale.²⁴ In this study, the internal consistency coefficient calculated for the total scale is Cronbach's alpha = 0.75; Cronbach's alpha = 0.95 for transcendence, Cronbach's alpha = 0.81 for conformity with nature, and Cronbach's alpha = 0.93 for anomie.

Statistical Analysis

Data obtained in the study were analyzed statistically using the TURCOSA software (Turcosa Analitik Ltd Co, Kayseri, Turkey, www.turcosa.com.tr). The skewness and kurtosis coefficients were used to assess the data's conformity to a normal distribution. Because the skewness and kurtosis coefficients were not in the range (-2, +2) (Table 1), nonparametric tests were used.²⁵ Number, percentage, minimum, maximum, mean, and Standard Deviation (SD) were used in the distribution of descriptive statistics. In the comparisons between 2 groups, the Mann-Whitney U test was used for quantitative variables. Correlations between

quantitative variables were examined with Spearman correlation analysis. The degree of the relationship was assessed in the correlation analysis as follows: 0.00-0.25 very weak, 0.26-0.49 weak, 0.50-0.69 moderate, 0.70-0.89 high, and 0.90-1.00 very high.²⁶ The Cronbach's alpha coefficient was used to calculate the scales' reliability coefficients. A value of $P < .01$ and $P < .05$ was accepted as statistically significant.

Ethical Considerations

Approval for the study was granted by the Kahramanmaraş Sütçü İmam University Local Ethics Committee (approval no: 19, dated: January 31, 2018). Written permission was obtained from the hospital where the study was conducted. The patients were informed about the study, and the consent was obtained from the patients who participated in the study. Permission to use the scale was given by the researcher who carried out the scale's validity and reliability study.

RESULTS

Evaluation was made of 113 patients, comprising 80 (70%) males and 33 (30%) females with a mean age of 55.09 ± 14.15 years (range, 40-59 years). Of the total patient group, 86% were married, 64.6% had an education level of primary school, and 81.4% had expenditure exceeding income. Previous hospitalization was reported by 87.6% of patients and a stay of 2 days in ICU was reported by 62.8%, and 54% had a chronic disease (Table 2).

The mean points of the SWS subscale points were determined as 73.29 ± 5.54 for the transcendental subscale, 34.25 ± 2.08 for the conformity with nature subscale, and 10.74 ± 5.99 for the anomie subscale. The points obtained by the patients in the scales were determined as follows: SWS mean total points of 96.80 ± 11.61 and PPNCS mean total points of 18.76 ± 13.37 (Table 3).

When the descriptive characteristics of the patients were examined with the mean points of the SWS and PPNCS scales, there was seen to be no significant relationship between gender, marital status, educational levels, income status, previous hospitalization, and the mean scale points ($P > .05$) (Table 4). A statistically significant relationship was determined between age groups and the SWS mean points ($P < .05$). The difference between the age groups in respect of transcendentalism ($P = .036$), conformity with nature ($P = .009$), anomie ($P < .001$) subscale points, and SWS total points ($P = .001$) was found to be statistically significant. The differences were determined to originate from the ≥ 56 years age group. The difference between the PPNCS mean points and age was not found to be significant ($P > .05$) (Table 4).

A statistically significant difference was determined between number of admissions to ICU groups and the SWS mean points ($P < .05$). The difference between the number of admissions to ICU groups in respect of transcendentalism ($P = .033$), conformity with nature ($P = .027$), anomie ($P < .001$) subscale points, SWS total points ($P = .001$), and PPNCS mean points ($P = .047$) was found to be statistically significant. It was found that the ≥ 4 times groups were where the differences originated (Table 4).

The length of stay in ICU groups and the other SWS subscale points and PPNCS mean points did not have a statistically significant difference ($P > .05$). It was determined that the difference in length of stay in ICU groups in respect of SWS total points ($P = .042$) was statistically significant. The differences in the SWS total points were determined to originate from the ≥ 3 days group (Table 4).

Table 1. Normality Test Results

Characteristics			Transcendentalism	Conformity with Nature	Anomie	SWS	PPNCS
			Statistic/Standard Error	Statistic/Standard Error	Statistic/Standard Error	Statistic/Standard Error	Statistic/Standard Error
Age	≤55 years	Skewness	-2.133/0.330	-1.854/0.330	1.314/0.330	-1.223/0.330	4.437/0.330
		Kurtosis	3.433/0.650	1.895/0.650	1.208/0.650	0.121/0.650	19.473/0.650
	≥56 years	Skewness	-4.895/0.306	-4.570/0.306	2.433/0.306	-3.873/0.306	3.353/0.306
		Kurtosis	24.667/0.604	20.960/0.604	6.946/0.604	14.549/0.604	9.983/0.604
Gender	Female	Skewness	-2.258/0.409	-2.138/0.409	1.353/0.409	-1.641/0.409	3.443/0.409
		Kurtosis	3.718/0.798	2.975/0.798	0.601/0.798	1.222/0.798	11.245/0.798
	Male	Skewness	-4.946/0.269	-3.554/0.269	2.106/0.269	-2.551/0.269	3.932/0.269
		Kurtosis	26.893/0.532	13.049/0.532	4.453/0.532	5.993/0.532	14.343/0.532
Marital status	Married	Skewness	-4.782/0.245	-3.314/0.245	2.210/0.245	-2.520/0.245	4.278/0.245
		Kurtosis	25.971/0.485	11.099/0.485	5.154/0.485	5.916/0.485	17.481/0.485
	Single	Skewness	-2.002/0.564	-2.044/0.564	0.937/0.564	-1.396/0.564	2.312/0.564
		Kurtosis	2.759/1.091	3.030/1.091	-0.188/1.091	0.494/1.091	4.116/1.091
Education level	Primary school	Skewness	-3.821/0.281	-3.616/0.281	2.292/0.281	-2.718/0.281	4.530/0.281
		Kurtosis	15.476/0.555	13.305/0.555	5.471/0.555	7.226/0.555	19.500/0.555
	Middle school	Skewness	-3.345/0.374	-2.496/0.374	1.619/0.374	-1.802/0.374	2.918/0.374
		Kurtosis	11.890/0.733	6.161/0.733	2.853/0.733	2.446/0.733	7.508/0.733
Income status	Income less than expenditure	Skewness	-3.558/0.251	-3.645/0.251	2.382/0.251	-2.545/0.251	4.325/0.251
		Kurtosis	12.683/0.498	13.836/0.498	6.300/0.498	6.068/0.498	17.860/0.498
	Equal income and expenditure	Skewness	-2.615/0.501	-1.827/0.501	0.930/0.501	-1.405/0.501	2.518/0.501
		Kurtosis	6.561/0.972	2.622/0.972	-0.117/0.972	0.839/0.972	5.194/0.972
Previous hospitalization	Yes	Skewness	-4.502/0.243	-3.096/0.243	2.071/0.243	-2.373/0.243	3.509/0.243
		Kurtosis	23.291/0.481	9.394/0.481	4.562/0.481	5.167/0.481	10.952/0.481
	No	Skewness	-2.350/0.597	-2.363/0.597	1.553/0.597	-2.038/0.597	3.742/0.597
		Kurtosis	4.224/1.151	4.323/1.154	1.394/1.154	2.987/1.154	14.000/1.115
Number of admissions to ICU	≤3 times	Skewness	-2.969/0.325	-2.361/0.325	1.513/0.325	-1.756/0.325	2.930/0.325
		Kurtosis	9.597/0.639	5.166/0.639	2.148/0.639	2.242/0.639	7.483/0.639
	≥4 times	Skewness	-5.770/0.311	-4.480/0.311	2.725/0.31	-3.200/0.311	5.246/0.311
		Kurtosis	36.134/0.613	21.692/0.613	8.325/0.613	10.433/0.613	26.554/0.613
Length of stay in ICU	≤3 days	Skewness	-3.851/0.285	-2.719/0.285	1.755/0.285	-2.093/0.285	5.692/0.285
		Kurtosis	17.231/0.563	7.301/0.563	3.473/0.563	3.669/0.563	35.600/0.563
	≥4 days	Skewness	-5.915/0.365	-4.084/0.365	2.408/0.365	-2.897/0.365	2.468/0.365
		Kurtosis	36.600/0.717	17.498/0.717	5.570/0.717	8.872/0.717	4.390/0.717

ICU, intensive care unit; PPNCS, Patient Perception of Nursing Care Scale; SWS, Spiritual Well-Being Scale.

In the correlation analysis between the scales shown in Table 5, it was determined that there was a weak negative correlation between PPNCS and SWS total score ($r = -0.348$; $P < .001$) and the sub-dimensions transcendentalism ($r = -0.239$; $P < .05$) and conformity with Nature ($r = -0.244$; $P < .05$). It was found that there was a weak positive correlation between PPNCS and the anomie sub-dimension ($r = 0.356$; $P < .05$). A statistically significant weak negative correlation was found between the Patient Nursing Care Perception Scale and the Mental Well-Being Scale. It indicates that as the perception of nursing care of the patients increases, their mental well-being decreases ($P < .05$) (Table 5).

DISCUSSION

Patients with heart disease experience pain and respiratory distress, which contributes to their anxiety and depression. Furthermore, patients have a fear of death, which makes it difficult for them to return to regular daily life, and as the frequency of the patient's complications increases, so does the rate of re-hospitalization.^{27,28} The emotional and spiritual requirements of the patients are affected by the events they encounter. Patients who have met their spiritual requirements accept their illness and look forward to a brighter future. This situation is beneficial to the patient's recuperation and increases their sense of hope for the

Table 2. Characteristics of the Patients

Characteristics	n	%
Gender		
Female	33	30.0
Male	80	70.0
Age (years)		
≤55	52	46.0
≥56	61	54.0
Mean age (years)	55.09 ± 14.15	
Marital status		
Married	97	86.0
Single	16	14.0
Education level		
Primary school	73	64.6
Middle school	40	35.4
Income status		
Income less than expenditure	92	81.4
Equal income and expenditure	21	18.6
Previous hospitalization		
Yes	100	87.6
No	13	12.4
Number of admissions to ICU		
≤3 times	47	41.6
≥4 times	53	46.9
Length of stay in ICU		
3 days	71	62.8
≥4 days	42	37.2

future.^{4,29} It is critical to integrate spiritual care in the nursing care process in order to maintain a standardized and professional level of spiritual care.¹⁵ Therefore, the results obtained in this study are discussed in the light of the relevant literature with the thought that they could contribute to the provision of spiritual care.

In this study, the SWS level of the patients was found to be high. When dealing with disease, patients may use either positive or negative spiritual coping mechanisms.³⁰ Spiritual difficulties are common among patients with life-threatening illnesses, and they require spiritual support.³¹ Erdoğan and Koç³² determined that the SWS scores of the patients treated in the intensive care unit were to be high. Darvishi et al³³ reported that the mean SWS total score of patients (43.47 ± 3.51) was determined. This level of SWS in these patients can be related to their religious and cultural life experiences.

Table 3. Distribution of Scale Points Obtained by the Patients

Scales	N	Minimum	Maximum	$\bar{x} \pm SD$
Transcendentalism	113	35.00	75.00	73.29 ± 5.54
Conformity with nature	113	24.00	35.00	34.25 ± 2.08
Anomie	113	7.00	35.00	10.74 ± 5.99
SWS total	113	51.00	103.00	96.80 ± 11.61
PPNCS total	113	15.00	75.00	18.76 ± 13.37

PPNCS, Patient Perception of Nursing Care Scale; SWS, Spiritual Well-Being Scale.

In this study, it was determined that the mean PPNCS total score was low. In the study of Aydın and Kaşıkçı,³⁴ the patients' mean PPNCS score was found to be high. Özşaker et al³⁵ reported that the mean PPNCS total score of patients hospitalized to the surgical clinics of a university hospital was found to be high. The difference in mean scores could be due to a sample size difference among the patients in the study or the patients' hospitalization status.

The results of this study showed that in the comparisons of the SWS points, there was no significant difference in the gender, occupation, education level, income level, marital status, and PPNCS points. Daştan and Buzlu³⁰ reported that more female and low socio-economic level patients preferred spiritual coping methods. However, studies by Caldeira et al³⁶ and Ata and Kılıç³⁷ determined that as the education level increased, the mean spirituality points also increased. In a study by Pinho et al,³⁸ it was stated that the lower the education level of the patient, the greater the search for religion/spirituality. In a study by Kersu et al,³⁹ educational level was reported to affect the PPNCS level, whereas gender had no effect. Another study also showed no difference in sociodemographic characteristics according to PPNCS.⁴⁰ The results of the current study are consistent with the findings of these studies.

In the current study, the transcendentalism, conformity with nature, and SWS total points of patients in the ≥ 56 years age group were determined to be significantly higher than those of the other age groups. It has been reported that elderly patients need more religious/religious care services than young or male patients.⁴¹ Daştan and Buzlu³⁰ reported that elderly patients preferred spiritual coping methods. Martins et al⁴² reported that there were no statistically significant relationships between age and SWS scores. This result suggests that patients in this age group saw their lives as empty and meaningless; they had negative thoughts because of the disease and their search for religion or spirituality was high. The results of the current study are consistent with the findings of these studies.

In the current study, the transcendentalism, conformity with Nature, and SWS total points of patients in the ≥4 times group were determined to be significantly higher than those of the other groups. When patients stay for a long time in ICU, they may be exposed to unfamiliar sounds and lights. In addition, disturbed sleep patterns, being bedridden, not seeing friends and family, painful procedures, and device dependence can cause problems such as anxiety, fear, sleeplessness, agitation, delirium, and depression in patients. This can cause spiritual distress and delay the recovery of the patient.² In the study of Cheng et al,⁴³ a higher frequency of hospitalization was associated with a higher level of SWS. In a study of Meneguín et al,⁴⁴ it was determined that there is a relationship between the length of stay in the hospital and SWS. Erdoğan and Koç³² stated that the frequency of hospitalization did not have an effect on SWS. Dehghanrad et al⁴⁵ determined that the length of hospital stay was significant for the SWS of the relatives of the patients. Consistent with the literature, it was seen in the current study that as the length of stay in ICU increased, SWS was also seen to increase. This result could be attributed to the perceptions of the patients of approaching God in ICU and the orientation of their spiritual feelings.

In this study, a weak negative correlation was found between PPNCS and SWS total score. It is stated that nurses do not have enough knowledge about spiritual needs, do not consider

Table 4. Comparison of Scales with Patient Characteristics

Characteristics	n	Transcendentalism, Mean Rank (Minimum–Maximum)	Conformity with Nature, Mean Rank (Minimum–Maximum)	Anomie, Mean Rank (Minimum–Maximum)	SWS, Mean Rank (Minimum–Maximum)	PPNCS, Mean Rank (Minimum–Maximum)
Age						
≤55 years	52	52.65 (60.00-70.00)	51.57 (28.00-35.00)	67.88 (7.00-35.00)	46.91 (65.00-103.00)	56.94 (15.00-75.00)
≥56 years	61	60.70 (35.00-75.00)	61.63 (24.-0035.00)	47.73 (7.00-25.00)	65.60 (51.00-103.00)	57.05 (15.00-75.00)
Z/P		-2.093 / .036*	-2.617 / .009*	-3.84 / < .001**	-3.24 / .001**	-.31 / .975
Gender						
Female	33	53.59 (60.00-75.00)	55.08 (28.00-35.00)	54.11 (7.00-24.00)	59.67 (71.00-103.00)	59.09 (15.00-75.00)
Male	80	58.41 (35.00-75.00)	57.79 (24.00-35.00)	58.18 (7.00-35.00)	55.90 (51.00-103.00)	56.14 (15.00-75.00)
Z/P		-1.142 / .253	-.645 / .519	-.657 / .511	-.611 / .541	-.786 / .432
Marital status						
Married	97	57.41 (35.00-75.000)	57.38 (24.00-35.00)	55.52 (7.00-35.00)	58.38 (51.00-103.00)	55.71 (15.00-75.00)
Single	16	54.50 (60.00-75.00)	54.69 (28.00-35.00)	66.00 (7.00-25.00)	48.63 (71.00-103.00)	64.81 (15.00-75.00)
Z/P		-.530 / .596	-.490 / .624	-1.305 / .192	-1.214 / .225	-1.858 / .063
Education level						
Primary school	73	57.99 (57.00-75.00)	58.61 (25.00-35.00)	54.34 (7.00-34.00)	59.69 (57.00-103.00)	56.57 (15.00-75.00)
Middle school	40	55.20 (35.00-75.00)	54.04 (24.00-35.00)	61.86 (7.00-35.00)	52.09 (51.00-103.00)	57.79 (15.00-75.00)
Z/P		-.695 / .487	-1.134 / .257	-1.285 / .199	-1.298 / .194	-.341 / .733
Income status						
Income less than expenditure	92	58.29 (57.00-75.00)	59.41 (25.00-35.00)	54.53 (7.00-35.00)	59.55 (57.00-103.00)	55.98 (15.00-75.00)
Equal income and expenditure	21	51.33 (35.00-75.00)	46.43 (24.00-35.00)	67.81 (7.00-28.00)	45.81 (51.00-103.00)	61.45 (15.00-75.00)
Z/P		-1.412 / .158	-2.635 / .008*	-1.844 / .065	-1.908 / .056	-1.246 / .213
Previous hospitalization						
Yes	100	56.96 (35.00-75.00)	56.92 (24.00-35.00)	56.25 (7.00-35.00)	57.66 (51.00-103.00)	57.36 (15.00-75)
No	13	57.29 (64.00-75.00)	57.57 (30.00-35.00)	62.29 (7.00-25.00)	52.36 (71.00-103.00)	54.46 (15.00-33.00)
Z/P		-.056 / .955	-.112 / .911	-.710 / .478	-.623 / .533	-.558 / .577
Number of admissions to ICU						
≤3 times	47	53.05 (48.00-75.00)	52.92 (24.00-35.00)	65.39 (7.00-34.00)	48.56(53.00-103.00)	60.85(15.00-75.00)
≥4 times	53	60.62 (35.00-75.00)	60.74 (25.00-35.00)	49.32 (7.00-35.00)	64.73(51.00-103.00)	53.47(15.00-75.00)
Z/P		-2.135 / .033*	-2.218 / .027*	-3.509 / < .001**	-3.451 / .001**	-1.989 / .047*
Length of stay in ICU						
3 days	71	54.97 (35.00-75.00)	55.19 (24.00-35.00)	61.07 (7.00-34.00)	52.62 (51.00-103.00)	55.12 (15.000-74.00)
≥ 4 days	42	60.43 (57.00-75.00)	60.06 (25.00-35.00)	50.12 (7.00-35)	64.40 (57.00-103.00)	60.18 (15.00-75.00)
Z/P		-1.376 / .169	-1.228 / .220	-1.889 / .59	-2.033 / .042*	-1.432 / .152

ICU, intensive care unit; PPNCS, Patient Perception of Nursing Care Scale; SWS, Spiritual Well-Being Scale; Z, Mann–Whitney U analysis. *Statistical significance at $P < .05$. ** Statistical significance at $P < .01$.

Table 5. Correlation Analysis of the Scales

Scale	Transcendentalism	Conformity with Nature	Anomie	SWS
PPNCS <i>r</i>	-0.239*	-0.244**	0.356**	-0.348**
<i>P</i>	.011	.009	< .001	< .001

r = correlation coefficient, Spearman correlation analysis: 0.00 < *r* < 0.25 very weak; 0.26 < *r* < 0.49 weak; 0.50 < *r* < 0.69 moderate; 0.70 < *r* < 0.89 high; 0.90 < *r* < 1.00 very high. PPNCS, Patient Perception of Nursing Care Scale; SWS, Spiritual Well-Being Scale. * $P < .05$. ** $P < .001$.

themselves responsible for providing spiritual care, and do not have enough time to meet spiritual needs.¹³ Yıldırım et al.,⁴⁶ reported that very little support was received for 72% of the spiritual needs of advanced stage cancer patients. Özçelik and Duran⁴⁷ determined that 47.1% of health professionals could not practice spiritual care in the clinic. According to the results of this study, nurses are unable to give spiritual care to their patients. It was found that in nurses with a high level of spirituality, the frequency of giving spiritual care increased.⁴⁸ Many variables influence spiritual care offered by nurses, including nurses' own belief systems,

hopes for life, and attitudes about death.⁴⁹ It has been suggested in the literature that spiritual care could help people cope with illness and death.⁵⁰ Gholamhossein et al⁵¹ found that the spiritual counseling provided to patients in their research of patients with myocardial infarction enhanced hope. Durmuş and Ekinci⁵² found that spirituality training was effective in reducing anxiety and depression in patients receiving hemodialysis treatment.

Study Limitations

One of the study's limitations is that it was conducted with patients who were treated in a hospital's critical care unit for a specific time period and provided their consent to participate in the study. The study's second limitation is that it was conducted only on patients of a certain age group who had coronary artery disease. Therefore, the results obtained are not generalizable. The primary limitation of the study was that a vast majority of the population where the study was conducted were Muslims.

The results of this study showed a significant relationship between SWS and age, number of admissions to ICU, and length of stay in ICU. There was a negative correlation between SWS and the perception of nursing care. In the light of these results, courses, seminars, and in-service training can be recommended to increase the awareness of nurses on the subject of spiritual care and for nurses to provide care by forming a care plan including the spiritual needs of the patient, and thus a more positive attitude towards spiritual care will ensure a more holistic and better quality nursing care.

Implication for Nursing Practice

Spiritual care includes the nurse's intuitive, altruistic, and holistic practices. When intensive care patients receive spiritual care, they rediscover the meaning of life, and their ability to cope with the problems caused by illness and existential crisis increases. Spiritual care can increase the patient's emotional power in coping with illness and pain and can directly or indirectly reduce their distress. For this reason, spiritual nursing interventions are seen as an important part of patient care.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Kahramanmaraş Sütçü İmam University (Date: January 31, 2018, Number: 19).

Informed Consent: Written permission was obtained from the hospital where the study was conducted. The patients were informed about the study, and their consent was obtained from the patients who participated in the study. Permission to use the scale was given by the researcher who carried out the scale's validity and reliability study.

Peer-review: Externally peer-reviewed.

Author Contributions: Conceptualization – D.S., Ö.C., P.T.K.; Formal Analysis – D.S.; Investigation – D.S., A.S.; Resources – A.S.; Data Curation – D.S., A.S.; Writing—Original Draft Preparation – D.S., A.S.; Writing—Review and Editing – Ö.C., P.T.K.

Declaration of Interests: The authors declare that they have no competing interest.

Funding: The authors declared that this study has received no financial support.

Etik Komite Onayı: Bu çalışma için etik komite onayı Kahramanmaraş Sütçü İmam Üniversitesi'nden (Tarih: 31 Ocak 2018, Sayı: 19) alınmıştır.

Hasta Onamı: Araştırmanın yapıldığı hastaneden yazılı izin alınmıştır. Hastalara çalışma hakkında bilgi verildi ve çalışmaya katılan hastalardan onam alındı. Ölçeğin kullanılmasına ölçeğin geçerlik ve güvenilirlik çalışmasını yapan araştırmacı tarafından izin verilmiştir.

Hakem Değerlendirmesi: Dış bağımsız.

Yazar Katkıları: Kavramsallaştırma – D.S., Ö.C., P.T.K.; Biçimsel Analiz – D.S.; Soruşturma – D.S., A.S.; Kaynaklar – A.S.; Veri Küratörlüğü – D.S., A.S.; Yazma – Orijinal Taslak Hazırlama – D.S., A.S.; Yazma – İnceleme ve Düzenleme – Ö.C., P.T.K.

Çıkar Çatışması: Yazarlar çıkar çatışması bildirmemişlerdir.

Finansal Destek: Yazarlar bu çalışma için finansal destek almadıklarını beyan etmişlerdir.

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