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The Effect of Nurses' Spirituality and Spiritual Care Status upon Death Perceptions

Papatya Karakurt [1*], Serhat Yıldırım [2]

[1]Erzincan Binali Yıldırım University Faculty of Health Sciences, Erzincan, Türkiye
[2]Erzincan Binali Yıldırım University, Health Sciences Institute, Erzincan, Türkiye

ABSTRACT:
Purpose: This study was done to investigate how nurses' spirituality and spiritual care status affected death perceptions.
Material and Methods: The population of this descriptive study was consisted of nurses who worked at palliative care clinic and intensive care unit of a city hospital located in a city. No sampling was made in the study and the study was completed with 91 nurses who volunteered to join the study. This study was conducted in a city hospital in a province between August and October 2019. To collect study data; Information Request Form used to collect characteristics of nurses' socio-demographic characteristics and spiritual care and death concept- and Spirituality and Spiritual Care Rating Scale and Death Attitude Profile Scale were used. To analyze the data; percentages, means, Kruskall Wallis, Mann Whitney-U, and correlation analysis were used.
Results: It was identified that nurses' average age was 31.87±7.0, 67% of them were female, 63.7% of them had undergraduate degree, 37.4% of them had a working period of 6-10 years and 81.3% of them were employed at intensive care units. Among the participant nurses, 64.8% did not receive on-the-job training on spiritual care, whereas 53.8% of them did not receive on-the-job training on the concept of death. Nurses' average total score of Spirituality and Spiritual Care Rating Scale was 42.93±6.08 and average total score of Death Attitude Profile Scale was 108.67±18.08. It was understood that there was a positive and weak correlation between nurses' spirituality, spiritual care status and their attitudes towards death.
Conclusion: According to the study result; it was found that status of nurses' perceiving spirituality and spiritual care concepts and their attitudes towards death were at moderate level. As the level in which nurses perceived spirituality and spiritual care concepts increased, so did their level of positive attitudes towards death. It may be recommended that nurses who are employed at critical units such as palliative care clinics and intensive care units should be given trainings about spirituality, spiritual care and death.
Keywords: *Spirituality; spirituality care; death perceptions; nurse*

**Corresponding author: Papatya Karakurt, email: papatyademirci@hotmail.com*

INTRODUCTION

The importance of individuals' spiritual needs has become clear with the adoption of the holistic approach, and new care has arisen in addition to the services used in health care, and due to the strong effect of the spiritual dimension on health-related behaviours and attitudes it has been regarded as the "primary element" of the holistic care philosophy (Erol, 2020; de Diego-Cordero et al., 2022a; de Diego-Cordero et al., 2022b). Spiritual care has been regarded as a critical component of palliative care, which has been recognized by the World Health Organization (WHO)'s definition of palliative care for nearly 15 years and is included in this definition. Spiritual care is of great importance for healthcare professionals who deliver individualized care by addressing the spiritual needs of patients in end-of-life care, and understanding spirituality by nurses will guide the planning of nursing care (Gijsberts et al., 2019; Erol, 2020; Rego et al., 2020). Spirituality, as one of the most fundamental traits of human beings, is a concept that incorporates different meanings and feelings for each person. People are able to attribute spirituality to subjective meanings in their

own experiences and lifestyles (Dossey and Keegan, 2013). Spirituality is a dynamic and internal aspect of humankind in which individuals seek ultimate meaning and purpose and experience important or sacred interactions with themselves, their families, others, their community, society, and nature. Beliefs, values, traditions, and practices are all ways in which spirituality may be expressed (Puchalski et al., 2014; de Diego-Cordero et al., 2022a; de Diego-Cordero et al., 2022b). In this context, spiritual care is particularly important in intensive care units (ICUs) and emergency rooms in assessing the complexity of illnesses, unanticipated changes and severity that cause loss of hope, anxiety, fear, and stress, and the critical condition of patients (de Diego-Cordero et al., 2022a). The significance of spiritual care in such settings has already been confirmed by some studies, which have indicated improvement in stress, self-esteem, and depression, as well as shorter lengths of hospital stays and lower expenses for health care (Riahi et al., 2018; Abu-El-Noor, 2016). It is very important for holistic nursing care that nurses are aware of the spiritual needs of their patients and are able to provide supportive spiritual service no matter what their own attitudes or spiritual thoughts towards death (Kudubeş et al., 2021).

Spiritual care, which has been shown to be beneficial in both the recovery of patients and the functioning of healthcare services, is brought to the forefront for nurses who work in critical care units. When providing care for patients, nurses should be aware of how they perceive spirituality and mortality. The way in which nurses perceive spiritual care and needs, as well as their willingness and sensitivity, all play a significant role in satisfying spiritual needs. In addition to all of these, the delivery of spiritual care is also affected by other factors such as the working environment and circumstances, communication with other healthcare professionals, and the patient's being open to communicate. Studies have indicated that one of the reasons why nurses have low perceptions of the spiritual support available to them is their attitudes towards death (Ergül and Bayık, 2004; Akgün et al., 2010; Daştan and Buzlu, 2010). However, spiritual care is seldom included into routine clinical practices by healthcare professionals. Various reasons, such as lack of understanding of the concept of spirituality among health care professionals, the imposition of their own beliefs on patients or the fear of offending patients, preference for biological topics, and lack of education have been represented as barriers to the incorporation of this care (de Diego-Cordero et al., 2022a). For nurses to be able to cope healthily with the stress, distress, and strain that arise because of frequent encounters with death, nurses must be mentally prepared, primarily for their mental health (Akarslan et al., 2024). The adoption of spirituality and spiritual care by nurses requires them to be aware of how they perceive death and the care they provide for patients. Thus, when nurses provide care to their patients in accordance with spiritual care, which is an element of holistic care, this will improve their perceptions of spiritual care.

MATERIAL and METHODS

Purpose and Type of the Study

The aim of this study is to examine how spirituality and spiritual care of nurses affects their perception of death. The study was conducted as a correlational descriptive study.

Research Questions

1- What is the level of nurses' perception of spirituality and spiritual care and their attitudes towards death?

2- Do the introductory characteristics of nurses affect their perception of spirituality and spiritual care and their attitudes towards death?

3- Do nurses' perception of spirituality and spiritual care affect their attitudes towards death?

Research Time and Setting

This study was conducted in a city hospital in a province between August and October 2019.

Research Population and Sample

The population of this descriptive study consisted of the nurses who worked in intensive care units and palliative care clinics within a city hospital in a province. Any sample selection was not used in the study and it was completed with the participation of 91 nurses who had voluntarily agreed to participate in the study. The data were gathered using a

descriptive characteristics form on the socio-demographic characteristics of nurses and their descriptive characteristics related to the concepts of spiritual care and death as well as Spirituality and Spiritual Care Rating Scale, and the Death Attitude Profile.

Data Collection Tools

Descriptive Characteristics Form: This form includes total 7 questions about nurses' age, gender, educational level, and whether or not they have had training in spiritual care and death (Ergül and Bayık, 2004; Ercan et al., 2018; Işık et al., 2009; Kaya, 2018).

Spirituality and Spiritual Care Rating Scale (SSCRC): McSherry et al., (2002) developed the Spirituality and Spiritual Care Rating Scale. This five point Likert-type scale has a total of 17 items. Its subscales include religiosity (items 4, 5, 13, and 16), spirituality and spiritual care (items 6, 7, 8, 9, 11, 12, and 14), and personalised care (items 1, 2, and 10). Each item is rated between [1] "Strongly Disagree" and [5] "Strongly Agree". On this scale, the first 13 items are scored directly, while the last four items are reversely scored. A total mean score being relatively near 5 signifies that the perception level of the spirituality and spiritual care concepts is high. The highest and lowest scores of the scale are 69 and 17, respectively with 31 for spirituality and spiritual care, 16 for religiosity, and 15 for personalised care. The Cronbach's α value for the scale was 0.64 in the study by McSherry et al.,. Ergül and Temel-Bayık (2007) conducted the validity and reliability study of the scale in Turkey, and the Cronbach's Alpha coefficient was determined to be 0.76 within the scope of internal consistency. Although there are subscales in the original version of the scale, Ergül and Temel-Bayık (2007) recommend an assessment based on the total score in their Turkish adaptation and validity study (McSherry et al.,2002; Ergül and Bayık-Temel, 2007). The Cronbach's Alpha value in this study was determined to be 0.67.

Death Attitude Profile (DAP): Wong et al., (1994) developed the Death Attitude Profile to assess individuals' attitudes towards death. This multidimensional and Likert type scale has 32 items, that are rated between [1] "Strongly Disagree" and [7] "Strongly Agree". The Death Attitude Profile is based on the view that death exists and assesses attitudes towards death with five subscales: fear of death, death avoidance, neutral acceptance, approach acceptance, and escape acceptance. As scores are gotten for each subscale of the scale, the total score of the scale may eventually be obtained. The most important advantage of the Death Attitude Profile is that it can directly assess the type and degree of acceptance of death, rather than assuming that it is a consequence of low death concern (Wong et al., 1994). Işık et al., (2009) conducted the Turkish validity and reliability study of the scale. DAP consists of 26 items. This is a seven point Likert-type scale that is rated from "Strongly Disagree" to "Strongly Agree". The scale includes reverse items (items 2, 3, 6, 7, 9, 12, 13, 14, 15, 17, 18, 20, 21, and 25). The higher the total score achieved on the scale, the more positive the attitude towards death (Işık et al., 2009). The scale was reduced to three subscales in its reliability and validity study. Those subscales are Neutral Acceptance-Approach Acceptance, Escape Acceptance and Fear of Death and Death Avoidance (Işık et al., 2009). The Cronbach's Alpha value in this study was also determined to be 0.81.

Data Collection

The researcher collected data by visiting the unit where they worked, depending on the number of nurses in the unit, their availability, and work schedules. Following the necessary explanations, the volunteer nurses were provided with a form to participate in the study. It took an average of 25-30 minutes to complete the forms.

Data Analysis

The SPSS for Windows 25 software (Statistical Package for the Social Sciences Inc., Chicago, IL, ABD) was used to analyse the data. The data was analysed using numbers, percentages, minimum and maximum values, mean and standard deviations, and since the data were not normally distributed, the Mann Whitney-U test was utilized to compare paired groups, the Kruskal Wallis Analysis was performed to compare multiple groups, and the Spearman correlation analysis was used to compare continuous

variables (Büyüköztürk, 2014). The significance level was accepted as $p<0.05$ in the study.

Ethical Considerations

After acquiring ethical committee approval (30/05/2019-Protocol No: 06/01) from the Human Research Ethics Committee of Erzincan Binali Yıldırım University for the study, formal permission was received from the institution where the study would be conducted (28/08/2019-E 8191). The nurses were informed about the objective and advantages of the study and their verbal consent was acquired. They were assured that their personal data would be kept confidential.

RESULTS

Demographic Characteristics of the nurses

It was determined that the mean age of the nurses was 31.87±7.0, 67% were female, 63.7% had a bachelor's degree, 37.4% worked for 6-10 years and 81.3% worked in the intensive care unit. Among the participant nurses, 64.8% did not receive on-the-job training on spiritual care, whereas 53.8% of them did not receive on-the-job training on the concept of death (Table 1).

It was determined that the SSCRC total mean score of the nurses was 42.93 ± 6.08, and their DAP total mean score was 108.67 ± 18.08 (Table 2).

Table 1. Participant Demographic Characteristics (n=91)

Demographic Characteristics	n	%	
Gender			
Female	61	67.0	
Male	30	33.0	
Educational Level			
High School	8	8.8	
Associate Degree	22	24.2	
Bachelor's Degree	58	63.7	
Master's Degree and Doctorate	3	3.3	
Duration of Working			
0-5 years	26	28.6	
6-10 years	34	37.4	
11-15 years	18	19.8	
16-20 years	7	7.7	
21 years and more	6	6.5	
The Unit They Worked in			
Palliative Care	17	18.7	
Intensive Care	74	81.3	
Status of Receiving In-Service Training on Spiritual Care			
Yes	32	35.2	
No	59	64.8	
Status of Receiving In-Service Training on Death			
Yes	42	46.2	
No	49	53.8	
Age			
Mean SD:	31.87±7.0	Min: 19	Max: 54

SD: Standard Deviation

Table 2. Distribution of Nurses' Scores in SSCRC*, DAP**, and their Subscales (n = 91)

The Scales and their subscales	Min. score to be obtained	Max. to be obtained	Min. score obtained	Max. score obtained	Mean	SD
Spirituality and spiritual care	7.00	31.00	7.00	31.00	13.96	4.81
Religiosity	8.00	20.00	8.00	16.00	15.31	2.92
Personalised care	3.00	15.00	3.00	12.00	5.64	2.01
Total SSCRC	**17.00**	**69.00**	**29.00**	**61.00**	**42.93**	**6.08**
Neutral Acceptance	12.00	84.00	29.00	83.00	58.73	10.83
Escape Acceptance	5.00	35.00	6.00	30.00	19.03	5.28
Fear of Death and Death Avoidance	9.00	63.00	9.00	50.00	30.91	8.66
Total DAP	**3.50**	**5.00**	**49.00**	**141.00**	**108.67**	**18.08**

* SSCRC: Spirituality and Spiritual Care Rating Scale, ** DAP: Death Attitude Profile

When Table 3 was examined, it was found that the difference between the total mean score on spirituality and spiritual care was statistically significant based on the units they worked in, and status of receiving in-service training on spiritual care and death (p<0.05, p<0.001). The levels of spirituality and spiritual care were not affected by the nurses' gender, age, educational level, and length of service (p>0.05) (Table 3).

The difference in the DAP total mean score of the nurses included in the study based on their educational level and duration of working was statistically significant. The nurses' attitude towards death was not affected by their gender, age, the unit, spiritual care, and status of receiving training on spiritual care and death (Table 4). A weak positive correlation was found between nurses' spirituality and spiritual care and their death attitude (Table 5).

Table 3. Comparison of Descriptive Characteristics of the Nurses and their mean scores in the SSCRC and subscales (n=91)

Descriptive Characteristics	**n/%**	**Spirituality and spiritual care**		**Religiosity**		**Personalised care**		**Total SSCRC**	
		Mean	**SD.**	**Mean**	**SD.**	**Mean**	**SD.**	**Mean**	**SD.**
Gender									
Female	61(67.0)	14.33	5.09	15.05	2.82	5.92	2.05	43.49	6.34
Male	30(33.0)	13.20	4.16	15.83	3.10	5.07	1.82	41.80	5.42
		MW-U*=835.5 p=0.499		MW-U=791.0 p=0.222		MW-U=771.5 p=0.086		MW-U=791.0 p=0.294	
Educational Level									
High School	8(8.8)	12.50	4.72	16.00	3.85	6.00	2.73	43.50	6.63
Associate Degree	22(24.2)	13.36	4.35	14.41	2.46	5.95	1.89	41.64	6.16
Bachelor's Degree	58(63.7)	14.47	4.80	15.41	2.87	5.52	1.93	43.36	5.89
Master's Degree and Doctorate	3(3.3)	12.33	9.24	18.00	3.46	4.67	2.89	42.67	9.81
		KW**=1.353 p=0.717		KW=4.987 p=0.173		KW=2.249 p=0.522		KW=1.264 p=0.738	
Duration of Working									
0-5 years	26(28.6)	15.00	4.69	15.50	3.42	5.14	2.38	42.27	6.57
6-10 years	34(37.4)	13.05	4.45	16.00	2.86	5.41	1.69	43.15	5.87
11-15 years	18(19.8)	14.03	4.77	15.79	2.64	6.67	2.00	44.00	6.53
16-20 years	7(7.7)	15.00	5.50	13.89	3.01	6.29	1.80	42.00	5.94
21 years and more	6(6.6)	14.71	5.12	13.86	3.39	4.00	1.26	39.83	5.49
		KW=1.478 p=0.831		KW=7.942 p=0.094		KW=10.231 **p=0.037**		KW=2.687 p=0.612	
The Unit They Worked in									
Palliative Care	17(18.7)	15.29	2.34	14.53	1.97	6.24	0.97	45.18	3.61
Intensive Care	74(81.3)	13.65	5.18	15.49	3.08	5.50	2.16	42.42	6.42
		MW-U=473.0 p=0.110		MW-U=521.5 p=0.270		MW-U=481.5 p=0.127		MW-U=415.0 **p=0.029**	
Status of Receiving In-Service Training on Spiritual Care									
Yes	32(35.2)	11.28	4.28	17.00	3.28	4.53	1.90	40.44	4.66
No	59(64.8)	15.41	4.48	14.39	2.24	6.24	1.81	44.29	6.36
		MW-U=471.0 **p=0.000**		MW-U=518.0 **p=0.000**		MW-U=502.0 **p=0.000**		MW-U=554.5 **p=0.001**	
Status of Receiving In-Service Training on Death									
Yes	42(46.2)	12.02	4.02	16.50	3.16	4.93	1.87	41.05	4.71
No	49(53.8)	15.61	4.86	14.29	2.27	6.24	1.94	44.55	6.67
		MW-U=611.0 **p=0.001**		MW-U=618.0 **p=0.001**		MW-U=664.5 **p=0.003**		MW-U=685.5 **p=0.006**	
Age									
Mean SD: 31.87±7.0 (Min: 19 Max: 54)		r***=0.56 p=0.596		r=-0.219 **p=0.037**		r=0.61 p=0.567		r=-0.003 p=0.981	

* Mann Whitney-U test, ** Kruskal Wallis Analysis, *** Spearman's Correlation Analysis

Table 4. Comparison of Descriptive Characteristics of the Nurses and their mean scores in the DAP and subscales (n=91)

Descriptive Characteristics	n/%	Neutral Acceptance		Escape Acceptance		Fear of Death and Death Avoidance		Total DAP	
		Mean	SD.	Mean	SD.	Mean	SD.	Mean	SD.
Gender									
Female	61(67.0)	60.25	10.33	19.18	5.52	31.49	9.02	110.92	17.53
Male	30(33.0)	55.63	11.33	18.73	4.83	29.73	7.87	104.10	18.61
		MW-U*=751.0 p=0.166		MW-U=838.5 p=0.517		MW-U=789.5 p=0.289		MW-U=715.5 p=0.092	
Education Level									
High School	8(8.8)	62.38	10.61	19.50	6.41	28.63	5.10	110.50	15.17
Associate Degree	22(24.2)	56.86	10.60	18.09	4.40	28.86	10.46	103.82	18.63
Bachelor's Degree	58(63.7)	60.02	10.00	19.53	5.39	32.45	8.04	112.00	16.33
Master's Degree and Doctorate	3(3.3)	37.67	6.81	15.00	6.25	22.33	6.66	75.00	19.16
		KW**=01.248 **p=0.017**		KW=2.427 p=0.489		KW=6.298 p=0.098		KW=9.891 **p=0.020**	
Duration of Working									
0-5 years	26(28.6)	58.91	9.01	21.86	4.48	32.09	6.41	112.86	14.99
6-10 years	34(37.4)	57.06	11.98	18.21	4.76	28.53	10.34	103.79	19.10
11-15 years	18(19.8)	64.28	8.25	19.50	5.08	35.06	6.16	118.83	12.59
16-20 years	7(7.7)	53.57	8.62	16.14	5.43	32.43	5.94	102.14	11.80
21 years and more	6(6.6)	53.33	13.43	13.50	4.09	23.50	7.69	90.33	22.81
		KW=7.523 p=0.111		KW=9.084 p=0.059		KW=6.119 p=0.190		KW=13.394 **p=0.010**	
The Unit They Worked in									
Palliative Care	17(18.7)	59.00	8.40	19.47	4.21	29.35	11.10	107.82	12.73
Intensive Care	74(81.3)	58.66	11.36	18.93	5.52	31.27	8.04	108.86	19.16
		MW-U=626.0 p=0.976		MW-U=608.5 p=0.834		MW-U=576.0 p=0.589		MW-U=574.0 p=0.575	
Status of Receiving Any Training on Spiritual Care									
Yes	32(35.2)	57.22	10.12	19.69	5.11	28.50	8.40	105.41	17.80
No	59(64.8)	59.54	11.19	18.68	5.38	32.22	8.58	110.44	18.13
		MW-U=812.5 p=0.274		MW-U=826.0 p=0.326		MW-U=817.5 **p=0.049**		MW-U=761.0 p=0.128	
Status of Receiving Any Training on Death									
Yes	42(46.2)	57.48	11.55	18.76	4.74	29.52	7.97	105.76	17.39
No	49(53.8)	59.80	10.17	19.27	5.74	32.10	9.11	111.16	18.46
		MW-U=932.0 p=0.440		MW-U=946.0 p=0.508		MW-U=664.5 p=0.092		MW-U=819.5 p=0.095	
Age									
Mean SD: 31.87±7.0 (Min: 19 Max: 54)		r***=0.56 p=0.597		r=-0.286 **p=0.006**		r=-0.71 p=0.503		r=-0.115 p=0.277	

* Mann Whitney-U test, ** Kruskal Wallis Analysis, *** Spearman's Correlation Analysis

Table 5. Assessment of Correlation between the SSCRC, DAP, and their Subscales (n= 91)

The scales		Spirituality and Spiritual Care	Religiosity	Personalised care	SSCRC
Neutral Acceptance	r*	0.146	-0.105	0.264	0.204
	p	0.167	0.323	**0.011**	0.053
Escape Acceptance	r	0.134	-0.098	0.244	0.161
	p	0.206	0.356	**0.020**	0.127
Fear of Death and Death Avoidance	r	0.224	-0.289	0.300	0.162
	p	**0.033**	**0.005**	**0.004**	0.125
DAP	r	0.234	-0.230	0.373	0.247
	p	**0.026**	**0.028**	**0.000**	**0.018**

*Spearman's Correlation Analysis

DISCUSSION

Nurses who adopt a holistic approach to provide care should identify patients' spiritual needs, address spiritual care, and assess it in their nursing care (Yelen Akpınar and Aşti, 2021). In order to achieve this, nurses should be aware of spirituality and spiritual care, as well as their own death attitudes.

The results of the study revealed that the nurses had moderate perceptions of the concepts of spirituality and spiritual care, as well as moderate attitudes towards death (Table 2). Numerous studies including nurses working in different units indicated that their level of spirituality and spiritual care was moderate to high (Çelik et al., 2014; Uzelli Yılmaz et al., 2019; Dündar, 2021; Polat and Özdemir, 2022). Likewise, nurses' attitudes towards death were found to be moderate in a study conducted with nurses (Kaya, 2018). Nurses who adopt spirituality while providing care and are aware of their attitudes towards death would be more effective in providing holistic care.

Because of the yield of holistic care and the positive effects of spirituality on individuals, it is crucial for nurses to integrate spiritual care into their practices (Erol, 2020). Even though spiritual care has been acknowledged as the foundation of nursing practice and nurses have both the intention and the motivation to deliver spiritual care, the findings of the study indicated that many do not deliver this sufficiently (Burkhart and Schmidt, 2012), and this integral aspect of holistic care is often neglected (Momennasab et al., 2019). In this study, it was determined that the nurses' in-service training on spiritual care and death affected their levels of spirituality and spiritual care, although gender, age, education level, duration of working, and their unit did not. Mamier (2018) claims that the spiritual care practices of nurses who received spiritual care training increased in his study with nurses. The insufficiency of nurses' knowledge about spiritual care in a study conducted with nurses working in inpatient treatment services at a university hospital revealed that training was required on this matter and increasing the number of staff members in the clinic was important for spiritual care (Ercan et al., 2018). In their study, Uslu Şahan and Terzioğlu (2020) determined that more than half of the nurses in the oncology clinic were not trained in spiritual care. In another study, it was noticed that nurses in internal medicine and surgical clinics also had information requirements about spiritual support (Uzelli Yılmaz et al., 2019). Likewise, a study conducted by Dündar (2021) with nurses determined that many variables (gender, marital status, education level, the unit, and duration of professional experience) did not affect nurses' perception of spiritual care. A study by Çelik et al., (2014) with nurses revealed that the total working year, working type, weekly working hours, division, shift type, and past hospitalization did not affect the level of perception of spirituality and spiritual care. Differently from the study's result, another study reported that the age and spiritual well-being of the nurses who were included in the study had a direct and significant correlation with the attitudes that oncology nurses hold toward spiritual care (Khorami et al., 2018). The difference in the results of the study may be attributable to the fact that the nurses work in different units and have different socio-demographic characteristics. Also, the results of this study indicated that the nurses' attitudes towards death were affected by their duration of service and educational level, but gender, age, the unit, spiritual care, and status of receiving training on death did not have an effect on their attitudes towards death. Especially the education level of the nurses and the experiences they have gained during the working period had a positive effect on their attitudes towards death.

Nurses are in continual interaction with individuals of all ages and with different experiences and they are exposed to a variety of crisis circumstances in which patients question the meaning and value of their lives. The spiritual beliefs and values held by both the patient and the nurse affect the capacity to manage crisis circumstances. To cope with spiritually the patient they care, nurses must first be aware of their own spiritual values and have a perspective that can assess the patient's and his/her family's condition, as well as their spiritual coping mechanisms. It is of the utmost importance for nurses to satisfy the spiritual needs of individuals in accordance with holistic care and reflect this onto their nursing care (Erol, 2020). This study revealed that spirituality and spiritual care of nurses affected their attitude towards death. In a study, it was

observed that the positive attitudes of nurses towards death positively affected their perception of spiritual support (Selvi, 2019). In another study, a positive correlation was found between nurses' spiritual well-being and their attitudes towards spiritual care (Khorami et al., 2018). Since spirituality is a concept that incorporates the notion of death, the consideration that nurses devote to spirituality would increase their attitudes towards death.

Limitations

Since this study was conducted in a single center and the nurses who worked in intensive care units and palliative care clinics. The research was conducted in a specific region; thus, it should be repeated in different populations as cultural and social norms may affect the result. More studies are required in order to repeat these research results in countries with different health systems.

CONCLUSION

Consequently, it was determined that the nurses had moderate perceptions of the concepts of spirituality and spiritual care, as well as moderate attitudes towards death. As the nurses' perception level of the concepts of spirituality and spiritual care increased, so did their positive attitude towards death.

In the light of these findings, it may be asserted that providing the nurses who are assigned to critical points, such as palliative care clinics and intensive care units with training on spirituality, spiritual care, and death as well as paying attention to these characteristics when planning the nurse workforce in clinics where end-of-life care is delivered, would improve the quality of nursing care.

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Compliance with Ethical Standards

Conflicts of interest the authors declares no conflicts of interest with respect to the authorship and/or publication of this article.

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