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ASSESSMENT OF NURSES' COMPETENCE IN PROVIDING SPIRITUAL CARE IN A TERTIARY HEALTHCARE SETTING IN DISTRICT MARDAN: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: *In holistic nursing practice, spiritual care is a crucial component, especially when it comes to acute, chronic, and end-of-life care. Nurses worldwide report differing degrees of proficiency in delivering spiritual care, despite its acknowledged significance.*

Objective: *To assess the level of nurses' competence in providing spiritual care in a tertiary healthcare setting in District Mardan.*

Methods: *A descriptive cross-sectional study was conducted among 175 registered nurses working in medical, surgical, critical care, and emergency units. Data were collected using a socio-demographic questionnaire and the 27-item Spiritual Care Competence Scale (SCCS). Data were analyzed using descriptive statistics and Chi-square test.*

Result: *A moderate to high level of competence was indicated by the total mean spiritual care competence score of 3.89 ± 0.547. Excellent internal consistency was shown by the SCCS (Cronbach's alpha = 0.920). Spiritual care competency was significantly correlated with age (p = 0.018), professional experience (p = 0.029), and prior spiritual care training (p = 0.042), but not with gender, religion, educational level, or unit/ward (p > 0.05). The majority of participants were Muslim (98.9%), female (64.0%), between the ages of 20 and 25 (33.7%), and had a BSN or Post-RN BSN (92.6%). 79.4% of nurses reported having previously received spiritual care training.*

Conclusion: *Nurses demonstrated a satisfactory level of spiritual care competence, which was significantly influenced by age, clinical experience, and prior training. These findings highlight the importance of experiential learning and structured spiritual care education to strengthen holistic, patient-centered nursing practice.*

Keywords: *Spiritual care, nursing competence, holistic care, SCCS, tertiary hospital, Pakistan*

INTRODUCTION

1.1 Background of the Study

The physical, psychological, social, cultural, and spiritual aspects of health are all included in holistic nursing care. Particularly during disease, pain, and end-of-life circumstances, spiritual care focuses on recognizing and meeting patients' needs for meaning, purpose, hope, faith, connectedness, and inner calm. Neglecting the spiritual aspect may jeopardize overall patient results and satisfaction, as modern health care increasingly acknowledges(1-3).

Spiritual care is emphasized by international nursing organizations, such as the International Council of Nurses (ICN), as a fundamental ethical and professional duty in nursing practice (4). Research indicates that patients' coping mechanisms, emotional stability, treatment compliance, recovery paths, and quality of life are all positively impacted by spiritual well-being (5,6). Particularly in chronic illness, cancer, and palliative care settings, patients who receive sufficient spiritual support report reduced levels of anxiety, sadness, and spiritual distress (7,8).

Spiritual care is still not always used in clinical settings, despite its significance. When it comes to identifying and meeting spiritual needs, nurses often express ambiguity, lack of confidence, and inadequate training (9,10). With a pooled mean score of 70.51 (95% CI: 70.23–70.79), a recent meta-analysis showed that nurses' competence in providing spiritual care worldwide is still at a modest level, underscoring a continuing gap between knowledge, attitudes, and practice (11). More than 90% of nurses recognize spirituality as a crucial part of holistic care, yet less than 40% regularly evaluate spiritual requirements in their everyday work, according to Ronaldson et al. (12).

Spirituality is highly ingrained in sociocultural and religious life in South Asian and Islamic healthcare systems. Holistic nursing principles are strongly aligned with Islamic beliefs, which place a strong emphasis on compassion, dignity, patience, and spiritual support throughout illness (13). However, many low- and middle-income nations, including Pakistan, still lack institutional norms, standardized evaluation instruments, and organized spiritual care education (14,15). According to local research, Pakistani nurses place a high importance on spirituality, although they frequently exhibit mediocre competence and express a great desire for formal education and organizational assistance (16,17).

District Mardan, located in Khyber Pakhtunkhwa, represents a culturally and religiously rich region where patients' spiritual needs are particularly significant. However, there is little empirical data on nurses' ability to provide spiritual care in this context. In this situation, evaluating spiritual care competency is crucial for producing local evidence, influencing nursing education, and enhancing comprehensive patient-centered care.

1.2 Problem Statement

Due to a lack of organizational support and training, nurses working in tertiary healthcare settings in District Mardan may not be sufficiently competent to regularly assess and manage patients' spiritual needs, despite the fact that spiritual care is an essential part of holistic nursing practice.

1.3 Objectives of the Study

1. To assess the level of nurses' competence in providing spiritual care.
2. To describe the socio-demographic and professional characteristics of nurses.
3. To evaluate the reliability of the Spiritual Care Competence Scale in the local context.
4. To determine the association between socio-demographic factors and spiritual care competence in a tertiary healthcare setting.

1.4 Significance of the Study

This study provides local evidence on nurses' spiritual care competence, which may guide curriculum development, in-service training programs, and institutional policies aimed at improving holistic patient care.

1.5 Operational Definitions

Spiritual Care Competence: Assessed using the modified SCCS questionnaire, this competency measures nurses' capacity to identify and address patients' spiritual and existential needs. The modified SCCS questionnaire adopt a 5-point Likert scale to rate each item. The overall competency score is calculated by summing the scores of all items. A score of 75% or higher indicates high competency, a score between 50-74% indicates moderate competency, while a score lower than 50% indicates that nurse nurses need improvement.

Nurse: A registered professional nurse who is now directly caring for patients in a tertiary healthcare environment is referred to as a nurse. The Spiritual Care Competence Scale (SCCS) is used to evaluate the nurse's degree of spiritual care competency.

CHAPTER 2: LITERATURE REVIEW

2.1 Concept of Spiritual Care in Nursing

The deliberate and compassionate support of patients' spiritual needs through presence, active listening, empathy, respect for beliefs, and encouragement of spiritual practices when desired

is known as spiritual care in nursing (18). It encompasses more general existential issues like meaning, hope, forgiveness, and inner peace in addition to religious activity (19).

2.2 Spiritual Care Competence

The ability of nurses to incorporate spiritual care into clinical practice using the proper knowledge, abilities, attitudes, and behaviours is known as spiritual care competency. Spiritual care competence was defined by Van Leeuwen et al. as a multifaceted construct with six domains: professionalization and quality improvement, communication, personal support and counselling, referral to spiritual care professionals, assessment and implementation of spiritual care, and attitude toward patients' spirituality (20). The Spiritual Care Competence Scale (SCCS) exhibits good psychometric qualities and has been extensively evaluated in a variety of cultural situations (21, 22).

2.3 Global Evidence on Spiritual Care Competence

Nurses' spiritual care competency is generally found to be moderate in international studies. Despite recognizing the significance of spirituality in care, the majority of nurses exhibit mediocre skill, according to a systematic review and meta-analysis including several nations (11). Major obstacles include lack of education, time limits, fear of imposing beliefs, and organizational impediments, according to studies from Europe, Asia, and North America (23–25).

2.4 Spiritual Sensitivity, Empathy, and Moral Sensitivity

Several studies have explored factors influencing spiritual care competence. According to Dewi et al., there was a substantial positive link between spiritual care competence (mean 91.92 ± 15.22) and spiritual sensitivity (mean 51.19 ± 12.43) among nursing students (26). Jiang et al. found that nurses with greater moral sensitivity and empathy scored far higher on spiritual care competence tests, highlighting the significance of emotional intelligence and ethical awareness in providing spiritual care (27).

2.5 Evidence from Muslim and Middle Eastern Contexts

According to Heidari et al., 61% of Iranian nurses had a moderate level of spiritual care competency, which was favourably correlated with their years of experience and spiritual well-being (28). Research from other nations with a majority of Muslims indicates that although nurses have positive attitudes toward spirituality, their levels of competence are still moderate because of their lack of formal education and institutional support (29, 30).

2.6 Pakistani Context

Similar trends are found in Pakistani research. Sohail et al. found that healthcare workers had a modest level of spiritual care competence (mean = 3.52 ± 0.48), and they emphasized the need for organized training and supporting organizational policies (16). Further research from Pakistani tertiary hospitals highlights that spiritual care is frequently given informally, without standardized evaluation or documentation (17,31).

2.7 Research Gap

Local evidence from Khyber Pakhtunkhwa, especially District Mardan, is still lacking despite the growing body of international research on spiritual care competency. To evaluate nurses' competency and direct culturally relevant training and policy changes, context-specific research is required.

CHAPTER 3: MATERIALS AND METHODS

3.1 Study Design

This was a descriptive cross-sectional study.

3.2 Study Setting

The study was conducted in a tertiary healthcare hospital in District Mardan, Khyber Pakhtunkhwa, Pakistan.

3.3 Study Duration:

The study duration was 6 months.

3.4 Study Population:

The target population consisted of all registered nurses working in medical, surgical, emergency and critical units.

3.5 Sample Size:

A sample of 175 nurses, with confidence interval of 95% and margin error of 5%, was selected using quota convenience sampling technique. To guaranteed representation from a variety of disciplines, nurses were grouped by department.

3.6 Inclusion Criteria
Registered nurses providing direct patient care with at least six months of clinical experience were included.

3.7 Exclusion Criteria
Non-clinical or administrative nursing staff.
Those who were unwilling to participate.

3.8 Data Collection Tools
Data were collected using two instruments:

1. A structured socio-demographic questionnaire covering age, gender, religion, education, experience, unit, and prior training.
2. The Spiritual Care Competence Scale (SCCS), a 27-item instrument rated on a Likert scale.

3.9 Validity and Reliability
Previous research has shown that the SCCS has excellent validity. With a Cronbach's alpha of 0.920, the instrument demonstrated high internal consistency in the current study, exceeding the acceptable threshold of 0.70 (20,21).

Table 1. Data reliability Test

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	No. of Items (Questions)
0.920	0.920	27

3.10 Data Collection Procedure
After obtaining permission from hospital administration, participants were approached during duty hours. Written informed consent was obtained prior to questionnaire distribution.

3.11 Data Analysis Procedure
Data were analyzed using SPSS version 27. The data was summarized using descriptive statistics, such as means, standard deviations, percentages, and frequencies. The Chi-square test was used in inferential statistics to investigate the relationship between sociodemographic factors and nurses' spiritual care competency. Statistical significance was defined as a p-value of less than 0.05. For clarity and convenience of comprehension, the results were displayed as tables and figures.

CHAPTER 4: RESULT
Table 2. Socio-Demographic Characteristics of Participants (N=175)

Variables	Classification	N	%
Age	20-25	59	33.7
	26-30	43	24.6
	31-35	42	24
	36-40	24	13.7
	40 and above	7	4
Gender	Male	63	36
	Female	112	64
Religion	Islam	173	98.9
	Christianity	2	1.1
Education	Diploma	9	5.1
	BSN	88	50.3
	Post RN BSN	74	42.3
	MSN	4	2.3

Experience	<1	33	18.9
	1-3	45	25.7
	4-6	48	27.4
	7-10	35	20
	>10	14	8
Unit/Ward	Medical	49	28
	Surgical	60	34.3
	Critical Units	38	21.7
	Emergency	28	16
Prior Training in Spiritual Care	Yes	139	79.4
	No	36	20.6

4.1 Age Distribution

Among the 175 nurses who participated in the study, 33.7% (n = 59) were between the ages of 20 and 25, 24.6% (n = 43) were between the ages of 26 and 30, and 24.0% (n = 42) were between the ages of 31 and 35. Just 4.0% (n = 7) of nurses were 41 years of age or older, compared to 13.7% (n = 24) who were between the ages of 36 and 40. This suggests that the bulk of the nurses working in this environment are under 35 years old.

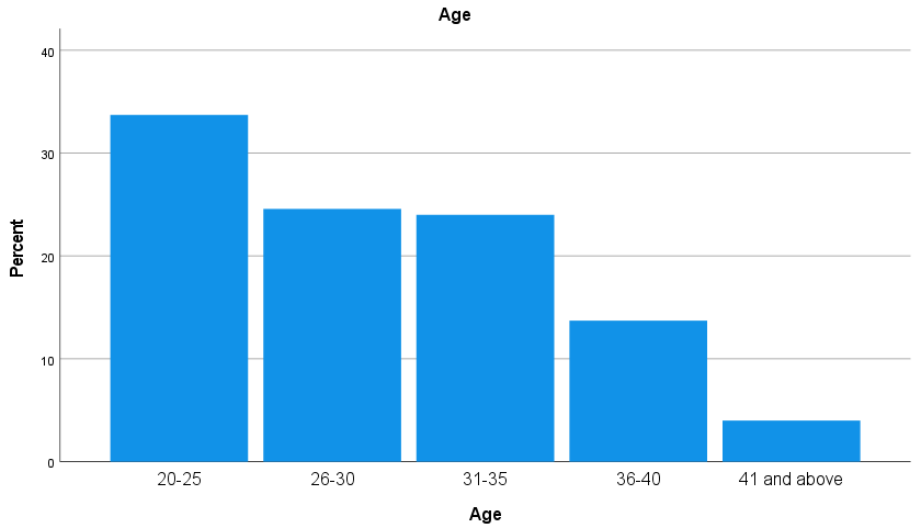

Figure 4.1. Age Distribution

4.2 Gender Distribution

Out of the total participants, 112 (64.0%) were female, and 63 (36.0%) were male, reflecting the female predominance commonly observed in the nursing profession in Pakistan.

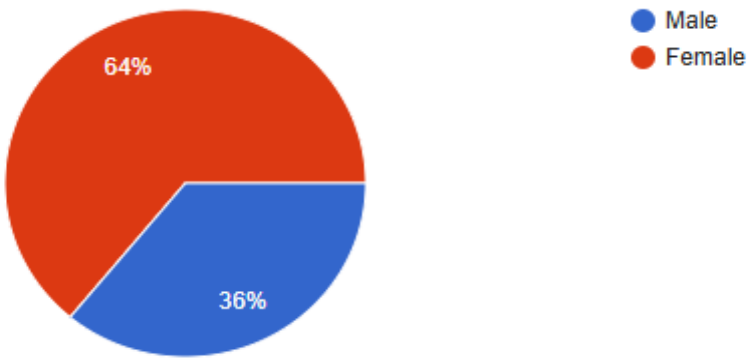

Figure 4.2. Gender Distribution

4.3 Religion

Most participants were Muslims (n = 173, 98.9%), while a small number identified as Christians (n = 2, 1.1%). This distribution aligns with the regional demographic context.

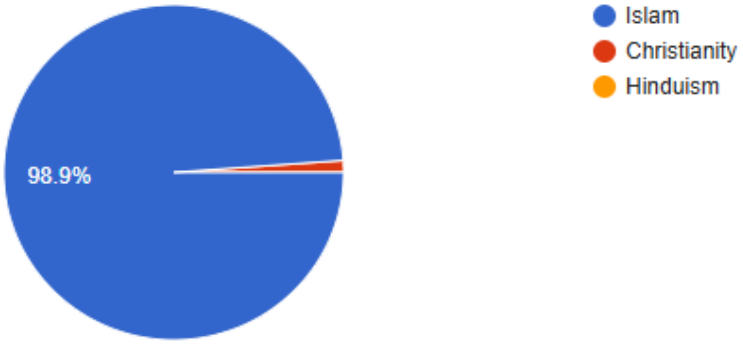

Figure 4.3. Religion

4.4 Educational Qualification

Half of the nurses held a Bachelor of Science in Nursing (BSN) degree (n = 88, 50.3%). Post-RN BSN holders comprised 42.3% (n = 74), diploma holders 5.1% (n = 9), and MSN graduates 2.3% (n = 4). The results indicate a predominantly graduate-level nursing workforce.

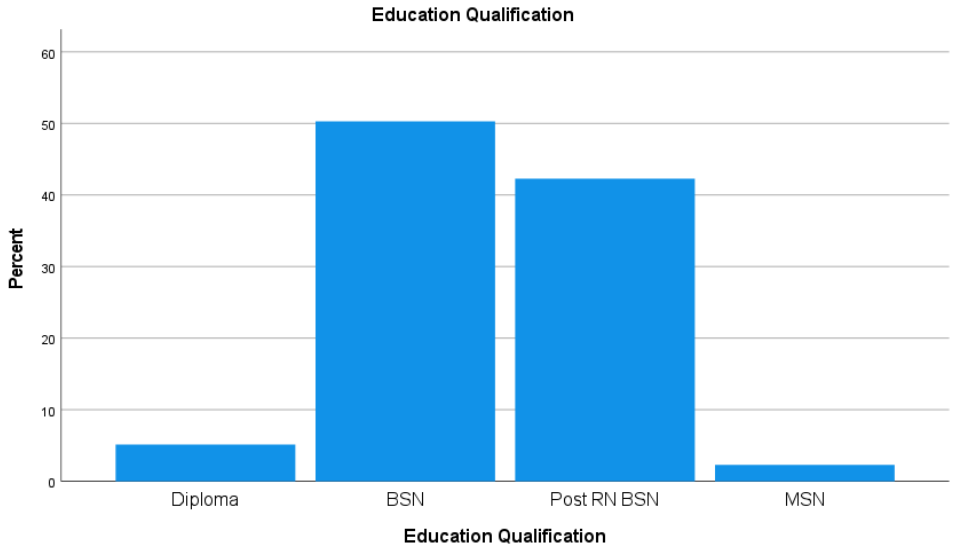

Figure 4.4. Education Qualification

4.5 Years of Nursing Experience

Nurses with 4–6 years of experience constituted the largest group (27.4%, n = 48), followed by 1–3 years (25.7%, n = 45), less than 1 year (18.9%, n = 33), 7–10 years (20.0%, n = 35), and more than 10 years (8.0%, n = 14). This distribution shows that most nurses have moderate clinical experience.

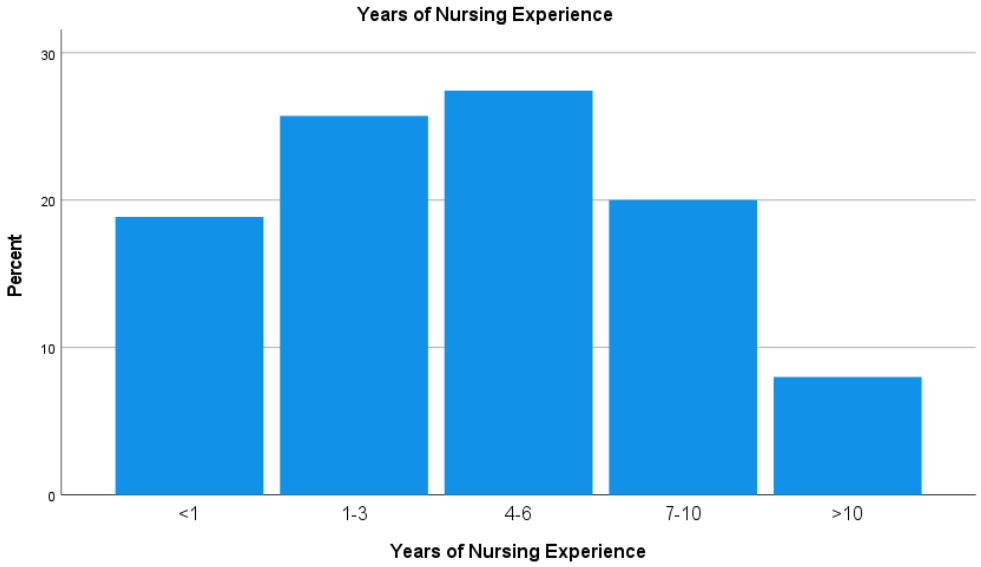

Figure 4.5. Years of Nursing Experience

4.6 Current Unit/Ward

Participants were employed across various clinical areas: surgical units (34.3%, n = 60), medical units (28.0%, n = 49), critical care units (21.7%, n = 38), and emergency departments (16.0%, n = 28).

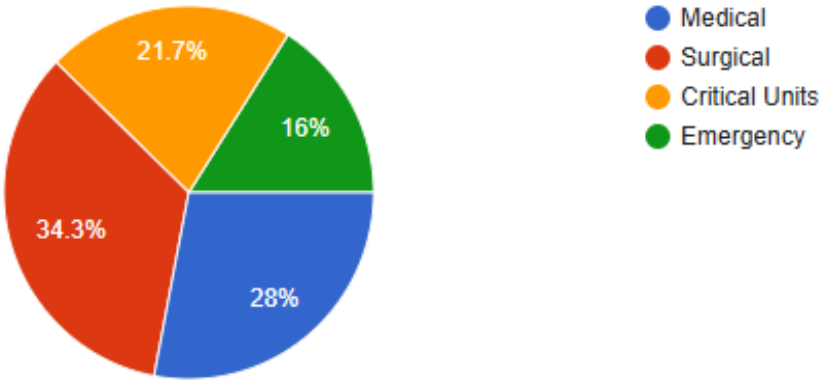

Figure 4.6. Current Unit/Ward

4.7 Prior Training in Spiritual Care

A majority of nurses (79.4%, n = 139) reported having received prior training in spiritual care, whereas 20.6% (n = 36) had not received such training. This indicates a relatively high exposure to spiritual care education among nurses in this setting.

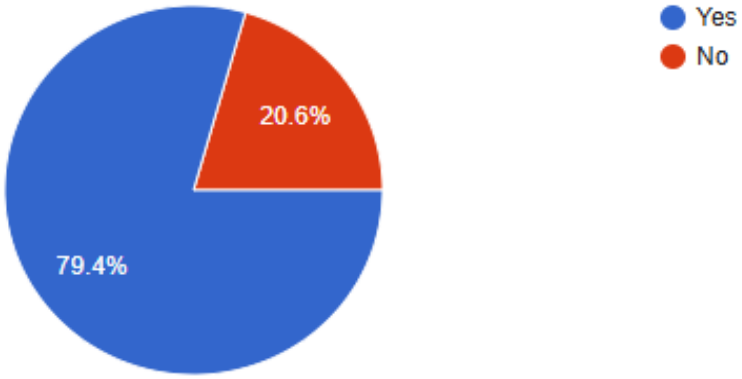

Figure 4.7. Prior Training in Spiritual Care

4.8 Reliability of the Instrument

The Spiritual Care Competence Scale (SCCS) demonstrated excellent internal consistency in this study. The Cronbach's alpha for the 27-item scale was 0.920, and the standardized Cronbach's alpha was also 0.920 as shown in table 1. These results indicate that the instrument is highly reliable and suitable for assessing nurses' spiritual care competence in this context.

4.9 Spiritual Care Competence Score

Table 3. Overall SCCS Score

Scale and Subscales		Mean	Std. Deviation
Subscales	Attitude toward Patient's Spirituality	4.02	0.794
	Communication	4.05	0.878
	Assessment and Implementation of Spiritual Care	3.81	0.878
	Referral	3.93	0.919
	Personal Support and Patient Counselling	3.91	0.985
	Professionalization and Improving Quality of Spiritual Care	3.79	1.028
	Spiritual Care Competence Scale (Total)	3.89	0.547

The findings indicate that nurses demonstrated a relatively moderate to high level of overall spiritual care competence, with a mean score of 3.89 (77.8%) with a standard deviation of 0.547 on the Spiritual Care Competence Scale. Among the subscales, the highest mean scores were observed for Communication (Mean = 4.05, SD = 0.878) and Attitude toward Patient's Spirituality (Mean = 4.02, SD = 0.794), reflecting positive attitudes and effective communication regarding patients' spiritual needs. Moderate to high competence was also noted in Referral (Mean = 3.93, SD = 0.919) and Personal Support and Patient Counselling (Mean = 3.91, SD = 0.985). Comparatively lower mean scores were reported for Assessment and Implementation of Spiritual Care (Mean = 3.81, SD = 0.878) and Professionalization and Improving Quality of Spiritual Care (Mean = 3.79, SD = 1.028), suggesting areas where further training and professional development may be beneficial.

4.10 Socio-Demographic factors showing significant Association

Statistical analysis of all socio-demographic factors was conducted by running the Chi-square Test through SPSS, out of these factors, age, experience, and prior training in spiritual care of the participants showed a significant association with spiritual care competence.

Table 4. Socio-Demographic factors showing significant Association

Variables	Classification	N	%	P-Value
Age	20-25	59	33.7	0.018
	26-30	43	24.6	
	31-35	42	24	
	36-40	24	13.7	
	40 and above	7	4	
Experience	<1	33	18.9	0.029
	1-3	45	25.7	
	4-6	48	27.4	
	7-10	35	20	
	>10	14	8	
Prior Training in Spiritual Care	Yes	139	79.4	0.042
	No	36	20.6	

4.10.1 Association between participants' age and overall test result

The association of research participants' age and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a significant relationship between research participants' age and overall SCCS score, with a p-value of 0.018.

4.10.2 Association between participants' experience and overall test result

The association of research participants' experience and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a significant relationship between research participants' experience and overall SCCS score, with a p-value of 0.029.

4.10.3 Association between participants' prior training in spiritual care and overall test result

The association of research participants' prior training in spiritual care and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a significant relationship between research participants' prior training in spiritual care and overall SCCS score, with a p-value of 0.042.

4.11 Socio-Demographic factors showing non-significant Association

Statistical analysis of all socio-demographic factors was conducted by running the Chi- square Test through SPSS, out of these factors, gender, religion, education, unit/ward of participants showed non-significant association with spiritual care competence.

Table 5. Socio-Demographic factors showing non-significant Association

Variables	Classification	N	%	P-Value
Gender	Male	63	36	0.471
	Female	112	64	
Religion	Islam	173	98.9	0.915
	Christianity	2	1.1	
Education	Diploma	9	5.1	0.066
	BSN	88	50.3	
	Post RN BSN	74	42.3	
	MSN	4	2.3	
Unit/Ward	Medical	49	28	0.667
	Surgical	60	34.3	
	Critical Units	38	21.7	
	Emergency	28	16	

4.11.1 Association between participants' gender and overall test result

The association of research participants' gender and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a non-significant relationship between research participants' gender and overall SCCS score, with a p-value of 0.471.

4.11.2 Association between participants' religion and overall test result

The association of research participants' religion and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a non-significant relationship between research participants' religion and overall SCCS score, with a p-value of 0.915.

4.11.3 Association between participants' education and overall test result

The association of research participants' education and spiritual care competence was evaluated statistically using a Chi-Square Test, and the results demonstrated a non-significant relationship between research participants' education and overall SCCS score, with a p-value of 0.066.

4.11.4 Association between participants' unit/ward and overall test result

The association of research participants' unit/ward and spiritual care competence was evaluated

statistically using a Chi-Square Test, and the results demonstrated a non-significant relationship between research participants' unit/ward and overall SCCS score, with a p-value of 0.667.

CHAPTER 5: DISCUSSION

5.1 Demographic Characteristics and Spiritual Care Competence

The majority of nurses in the tertiary healthcare setting in District Mardan were between the ages of 20 and 30, according to the study's findings. This result is in line with research done in Pakistan and other developing nations, where a significant percentage of hospital employees are early-career nurses as a result of recent increases in nursing education programs (6,8). Younger nurses may show an openness to holistic care techniques, but their lack of clinical expertise may limit their ability to confidently handle complicated spiritual issues, especially in patients who are severely sick or nearing the end of their lives (9).

Nearly two-thirds of the sample were female nurses, which is consistent with the gender distribution frequently documented in nursing literature both domestically and internationally (5,6,10). Previous research indicates that female nurses frequently report stronger spiritual sensitivity and empathy, which may positively influence spiritual care delivery, even though this study did not statistically assess gender differences in spiritual care competence (11). Other research, however, finds no discernible gender-based differences, suggesting that education and training have a greater impact on competence than gender alone (12).

In terms of religion, the majority of participants are Muslims, which is consistent with the demographics of both District Mardan and Pakistan as a whole. Spirituality is ingrained in everyday life and clinical interactions in Islamic healthcare settings, which may encourage nurses to participate in spiritual care activities (13). It has been demonstrated that nurses and patients who share similar religious views are more at ease, trustworthy, and willing to discuss spiritual issues (14).

5.2 Educational Qualification and Clinical Experience

A comparatively educated nursing workforce is indicated by the fact that the majority of research participants had a BSN or Post-RN BSN qualification. This result is consistent with national initiatives by regulatory agencies to switch from diploma-based to degree-level nursing education. Since higher education improves nurses' critical thinking, communication, and comprehension of holistic care principles, it has been repeatedly linked to improved spiritual care competency (5,15).

The largest group in this study consisted of nurses with four to six years of experience. According to earlier research, nurses with a moderate level of clinical experience are more suited to incorporate spiritual care into their regular practice because they have enough clinical exposure while still being enthusiastic about their work (7,16). On the other hand, nurses with very little or a lot of experience may be unconfident or suffer from burnout, which can have a detrimental effect on spiritual care involvement (17).

5.3 Training in Spiritual Care

The fact that over 75% of nurses said they had previously received spiritual care training was one of the study's noteworthy findings. This percentage is greater than that found in previous research conducted in Pakistan, where a significant obstacle to providing spiritual care was found to be a lack of formal training (6,18). A greater understanding of holistic nursing care and progressive curriculum changes may be the cause of the observed improvement.

International literature highlights that the sheer existence of training does not ensure competency, notwithstanding this encouraging conclusion. Effective practice is significantly influenced by spiritual care education's structure, quality, and practical focus (19). Experiential learning, reflective practice, and mentorship-based training greatly improve nurses' spiritual care competency, according to studies from Iran and Indonesia (3,5).

5.4 Overall Spiritual Care Competence

The findings indicate that nurses have a generally high level of spiritual care competence, as shown by the overall mean score of 3.89. This suggests that spirituality is acknowledged as an important aspect of holistic nursing care. Higher scores in communication and attitude toward patient's spirituality reflect nurses' openness and confidence in addressing patients' spiritual concerns, which supports effective therapeutic relationships and patient-centered care.

Moderate scores in referral and personal support and patient counselling imply that although nurses are willing to provide spiritual support, they may encounter practical barriers such as time limitations, unclear referral systems, or limited access to spiritual care services. Lower scores in assessment and implementation of spiritual care and professionalization and improving quality of spiritual care highlight gaps in systematic practice and formal training, possibly due to limited curricular emphasis and lack of institutional guidelines.

5.5 Reliability of the Spiritual Care Competence Scale

With a Cronbach's alpha of 0.920, the Spiritual Care Competence Scale showed outstanding internal consistency in this study. This result is consistent with the initial validation study by Van Leeuwen et al. and later research in Asia and the Middle East that found Cronbach's alpha values greater than 0.85 (7,13,21). The SCCS's strong reliability lends credence to its potential as a reliable and culturally sensitive tool for evaluating Pakistani nurses' spiritual care competency.

5.6 Association Between Socio-Demographic Factors and Nurses' Spiritual Care Competence

The current study looked at the relationship between nurses' spiritual care competency and sociodemographic factors. The results indicated that spiritual care competency was substantially correlated with age, professional experience, and prior spiritual care training, but not with gender, religion, educational level, or unit/ward. These findings suggest that targeted education and experiential learning have a greater impact on spiritual care competency than individual demographics.

Age and spiritual care competency were found to be significantly correlated ($p = 0.018$), indicating that older nurses are more adept at delivering spiritual care. This could be the result of greater emotional development, life experiences, and introspective capacity, all of which improve awareness of patients' spiritual requirements. International research has revealed similar results, with older nurses scoring higher on spiritual care competence [20,32,33]. Senior nurses are more comfortable addressing patients' spiritual problems, especially in culturally sensitive healthcare settings, according to Pakistani studies [13].

Spiritual care competence was also substantially correlated with professional experience ($p = 0.029$). Longer clinical experience increased a nurse's competency, perhaps as a result of their frequent exposure to end-of-life care, critical illness, and patient suffering. These results align with global research demonstrating the progressive development of spiritual care skills through clinical practice [10,20]. Similar data from Pakistan indicates that seasoned nurses are more adept at identifying and addressing patients' spiritual suffering [31].

The study also found a significant correlation ($p = 0.042$) between spiritual care competency and prior spiritual care training. Higher skill levels were shown by nurses with formal training, underscoring the value of organized education. This conclusion is corroborated by international research, which highlights how spiritual care training boosts nurses' self-assurance and capacity to deliver comprehensive care [20,23]. There are few possibilities for training in the Pakistani environment, however the evidence that is currently available shows that trained nurses have better spiritual care practices [13,31].

However, there was no significant correlation between gender and spiritual care ability ($p = 0.471$), suggesting that the skills of male and female nurses are similar. This result is consistent with research conducted both domestically and internationally that see spiritual care as a professional skill rather than a gender-based characteristic [32,34]. Similarly, religion did not substantially correlate with spiritual care competence ($p = 0.915$), indicating that respecting patients' views and values is more important for good spiritual care than personal religious affiliation [3,20].

Higher academic credentials by themselves do not guarantee greater ability in spiritual care, as evidenced by the lack of a significant correlation between educational level and spiritual care competency ($p = 0.066$). This result highlights gaps in nursing curriculum where spiritual care is not given enough attention during hands-on training [23]. Furthermore, spiritual care competency was not significantly impacted by unit or ward placement ($p = 0.667$), indicating that spiritual demands are present in all clinical settings.

5.7 Implications for Nursing Practice

The study's conclusions emphasize the necessity of enhancing spiritual care as a crucial part of standard nursing practice. Even though nurses showed adequate skill, consistent spiritual care delivery requires institutional support, clear guidelines, and interdisciplinary collaboration. Higher quality holistic care outcomes are reported by hospitals with supporting policies and access to chaplaincy or spiritual counsellors, according to prior research (14,22).

CHAPTER 6: CONCLUSION

In addition to providing physical care, spiritual care is an essential part of holistic nursing practice, meeting patients' needs for comfort, meaning, hope, and emotional wellbeing. The purpose of this cross-sectional study was to evaluate the spiritual care skills of nurses working in a tertiary healthcare facility in District Mardan. The study's conclusions offer important local evidence about Pakistani nurses' present level of spiritual care competency.

The overall mean score on the Spiritual Care Competence Scale showed that nurses had a moderate to high level of spiritual care competence. The instrument's remarkable internal consistency attests to the validity of the results. The majority of participants were young, degree-prepared nurses who had previously received spiritual care training and had moderate clinical experience, which may have improved their competency levels.

Notwithstanding these positive results, the study nevertheless identifies significant gaps. Spiritual assessment, implementation, and professional development were not consistently incorporated into ordinary clinical practice, despite the fact that many nurses had received some kind of spiritual care training. These gaps imply that spiritual care is frequently provided informally rather than via organized, empirically supported methods. Additionally, nurses may not be able to give comprehensive spiritual care, especially in critical and end-of-life conditions, due to the lack of defined institutional norms and insufficient interdisciplinary teamwork.

Overall, the study finds that although nurses in District Mardan's tertiary healthcare setting are competent enough to provide spiritual care, structured education, organizational support, and policy development are clearly needed to improve patient-centered, holistic nursing care.

6.1 Limitations

When evaluating the results, it is important to take into account the limitations of this study. The cross-sectional design limited the ability to establish causal relationships between socio-demographic factors and spiritual care competence. Data were collected from a single tertiary healthcare setting, which may limit the generalizability of the results to other hospitals or regions. A self-reported questionnaire was used to evaluate spiritual care competency, which could have resulted in response bias. Additionally, participants' responses might have been impacted by nurses' workload and time constraints.

6.2 Recommendations

Based on the findings of this study, the following recommendations are proposed:

6.2.1. Recommendations for Nursing Practice

- Regular spiritual assessment should be a part of nursing care, especially for patients with severe diseases, chronic illnesses, or end-of-life care.
- To maintain the continuity of holistic treatment, it should be encouraged to document patients' spiritual requirements and interventions.
- To assist nurses in handling difficult spiritual issues, interdisciplinary cooperation with counsellors, chaplaincy services, or religious leaders should be reinforced.

6.2.2. Recommendations for Nursing Education

- Evidence-based teaching methods should be used to explicitly incorporate spiritual care content into undergraduate and graduate nursing curriculum.
- The development of practical skills, reflective practice, and ethical issues pertaining to spiritual care should be highlighted in educational programs.
- To improve nurses' proficiency and self-assurance in delivering spiritual care, ongoing professional development programs and in-service training ought to be arranged.

6.2.3. Recommendations for Nursing Administration and Policy

- Hospital administrations should create explicit policies and procedures for providing spiritual care in clinical settings.

• To acknowledge spiritual care as a fundamental nursing duty, supportive organizational rules should be put in place.
• It is important to give nurses enough time, resources, and training opportunities so they may provide holistic care without sacrificing workload demands.

6.2.4. Recommendations for Future Research

• Future research should examine workload, workplace culture, and individual spirituality as factors affecting spiritual care competency.
• To further understand nurses' perspectives, experiences, and difficulties with spiritual care, qualitative study is advised.
• It is also recommended to conduct interventional studies to assess the efficacy of structured spiritual care training programs in Pakistani hospital settings.

REFERENCES

Sulmasy DP. A biopsychosocial-spiritual model for the care of patients at the end of life. The gerontologist. 2002 Oct 1;42(suppl_3):24-33.

Koenig HG. Religion, spirituality, and health: The research and clinical implications. International Scholarly Research Notices. 2012;2012(1):278730.

Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. Journal of palliative medicine. 2014 Jun 1;17(6):642-56.

International Council of Nurses. The ICN Code of Ethics for Nurses. Geneva: ICN; 2021.

Büssing A, Koenig HG. Spiritual needs of patients with chronic diseases. Religions. 2010 Nov 12;1(1):18-27.

Delgado C. A discussion of the concept of spirituality. Nursing science quarterly. 2005 Apr;18(2):157-62.

Peteet JR, Balboni MJ. Spirituality and religion in oncology. CA Cancer J Clin. 2013;63(4):280–9.

Vallurupalli M, Lauderdale K, Balboni MJ, et al. The role of spirituality and religious coping in the quality of life of patients with advanced cancer. J Support Oncol. 2012;10(2):81–7.

McSherry W, Jamieson S. An online survey of nurses' perceptions of spirituality and spiritual care. J Clin Nurs. 2011;20(11–12):1757–67.

Baldacchino DR. Teaching on the spiritual dimension in care: the perceived impact on undergraduate nursing students. Nurse Educ Today. 2008;28(4):501–12.

Wu LF, Tseng HC, Liao YC. Nurse spiritual care competence: a systematic review and meta-analysis. J Nurs Res. 2021;29(1):e135.

Ronaldson S, Hayes L, Aggar C, Green J, Carey M. Spirituality and spiritual caring in nursing education: a systematic review. J Clin Nurs. 2012;21(15–16):2236–51.

Rassool GH. Islamic counselling: An introduction to theory and practice. Routledge; 2015 Jul 16.

Yih C. The Impact of Cultural Diversity on End-of-Life Care. Religions 13: 644. Intercultural Theology vis-à-vis Ecumenical and Interreligious Dialogue. 2022:190.

World Health Organization. WHOQOL-SRPB field-test instrument: WHOQOL spirituality, religiousness and personal beliefs (SRPB) field-test instrument: The WHOQOL-100 questions plus 32 SRPB questions. World Health Organization; 2002.

Sohail MM, Qureshi NA, Iqbal N. Spiritual care competence among healthcare professionals in Pakistan: a cross-sectional study. J Relig Health. 2020;59(4):2038–50.

Riaz M, Ahmad M, Hussain S. Nurses' perceptions of spirituality and spiritual care in tertiary hospitals of Pakistan. Pak J Med Sci. 2018;34(4):863–8.

Puchalski C. Spirituality in health: the role of spirituality in critical care. Critical care clinics. 2004 Jul 1;20(3):487-504.

Narayanasamy A. Spiritual care and nursing practice: issues and trends. Br J Nurs. 2001;10(7):446–55.

Van Leeuwen R, Tiesinga LJ, Middel B, Post D, Jochemsen H. The effectiveness of an educational programme for nursing students on developing competence in the provision of spiritual care. Journal of clinical nursing. 2008 Oct;17(20):2768-81.

Van Leeuwen R, Tiesinga LJ, Middel B, Post D, Jochemsen H. The validity and reliability of an instrument to assess nursing competencies in spiritual care. Journal of clinical nursing. 2009 Oct;18(20):2857-69.

Musa AS, Pevalin DJ, Al Khalaileh M. Spiritual well-being, depression, and stress among hemodialysis patients in Jordan. J Holist Nurs. 2018;36(4):354–65.

Ross L, Giske T, van Leeuwen R, et al. Factors contributing to student nurses' competence in spiritual care. Nurse Educ Today. 2014;34(5):697–702.

Timmins F, Neill F. Teaching nursing students about spiritual care – a review of the literature. Nurse Educ Pract. 2013;13(6):499–505.

Taylor EJ, Mamier I, Ricci-Allegra P, Foith J. Self-reported frequency of nurse-provided spiritual care. Appl Nurs Res. 2017;35:30–5.

Dewi SP, Nurachmah E, Gayatri D. Spiritual care competence and spiritual sensitivity among nursing students. Enferm Clin. 2020;30(Suppl 2):441–4.

Jiang Q, Liu Y, Chen Y. Moral sensitivity, empathy, and spiritual care competence among nurses. Nurs Ethics. 2021;28(6):910–23.

Heidari A, Borujeni MG, Rezaei P, Abyaneh SK. Relationship between spiritual health and spiritual care competence among Iranian nurses. J Relig Health. 2017;56(4):1497–508.

Almutairi AF. Spiritual care practices among nurses in Saudi Arabia. J Holist Nurs. 2015;33(3):231–43.

Abu-El-Noor NI. Nurses' attitudes toward spiritual care in Gaza Strip hospitals. J Holist Nurs. 2016;34(2):138–47.

Khan Z, Sheikh S, Fatima S. Spiritual care practices in Pakistani hospitals: nurses' perspectives. J Pak Med Assoc. 2019;69(12):1824–9.

McSherry W, Jamieson S. The qualitative findings from an online survey investigating nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing. 2013 Nov;22(21-22):3170-82.

Ramezani M, Ahmadi F, Mohammadi E, Kazemnejad A. Spiritual care in nursing: a concept analysis. International nursing review. 2014 Jun;61(2):211-9.

Strang S, Strang P, TERNESTEDT BM. Spiritual needs as defined by Swedish nursing staff. Journal of clinical nursing. 2002 Jan;11(1):48-57.