Original Article

Nurses and Midwives Opinions about Spirituality and Spiritual Care

Melahat Akgun Kostak, PhD, MSN, BSN
Associate Professor, Trakya University, Faculty of Health Sciences, Department of Nursing, Edirne, Turkey

Ulfiye Celikkalp, PhD, MSN, BSN
Lecturer, Namık Kemal University, Health School Collage, Nursing Department, Tekirdag, Turkey

Correspondence: Melahat Akgun Kostak, Associate Professor, Trakya University, Faculty of Health Sciences, Department of Nursing, Edirne, Turkey. E-mail: akgunmel@yahoo.com

Abstract

Background: The concept of spirituality cannot be understood well enough by midwives and nurses because it is an abstract and complex concept and so spiritual care is less included in nursing practice.
Aim: This descriptive study was conducted to determine the opinions of nurses and midwives on spirituality and spiritual care.
Methods: The study sample consisted of 243 nurses and midwives working at the Health Practice and Research Centre of a University in Turkey. Data were collected from a personal information form and "The Spirituality and Spiritual Care Rating Scale".
Results: It was found that 28.8% of nurses and midwives had received information about spiritual care, and 46.5% had provided spiritual care to patients. Nurses and midwives who received information about spiritual care and gave spiritual care to their patients had higher perceptions of spiritual care ($p< 0.05$).
Conclusions: It was found that nurses' and midwives' knowledge of spirituality and spiritual care was insufficient and that those who received information about spirituality and spiritual care and gave spiritual care had higher perceptions of spirituality and spiritual care. It is important that spirituality and spiritual care subjects be included in nursing and midwifery education curricula and in-service training programmes after graduation.

Key words: Midwife, nurse, spirituality, spiritual care

Introduction

The most comprehensive approach adopted in delivering healthcare is the holistic approach. According to the holistic approach, an individual is a whole with physical, mental, emotional, socio-cultural and spiritual dimensions and each of these dimensions are interrelated and interdependent with the other (Baldacchino 2006, Biro 2012, Dastan & Buzlu 2010). Spiritual dimension of individual has become as important as the other dimensions with the delivery of healthcare to individuals with the holistic approach (Ergul & Temel 2004). However, Sapountzi-Krepia et al. (2003, 2005) argue that spirituality and has been understood and used differently in scientific work because of the elusiveness of the concept. Spiritual life, physical health and spiritual values are the same for most patients. Also, spiritual needs may increase during the course of a disease (Daaleman 2012, Wong, Lee & Lee 2008). Many patients state that spirituality plays an important role in their lives and they believe that spiritual care should be taken into account as a part of nursing care (Wong, Lee & Lee 2008). Studies conducted have revealed that spiritual dimension has an evident positive effect on health, well-being and quality of life (Coyle 2002, Draper, 2012, Ergul & Temel 2004, Hall 2006, Wallace & O'She 2007, Wong, Lee & Lee 2008). Although the importance of spiritual dimension in nursing care is not realized in the literature, it

is, however, stated that the concept is understood inadequately (McSherry & Jamieson 2011, Ozbasaran et al. 2011, Yilmaz & Okyay 2009) and in addition, it is generally neglected in health care because concrete service/work success is important (Baldacchino 2006).

Studies on the health results of spirituality in health and nursing practices have increased in the past twenty years (McSherry & Jamieson 2011, Daaleman 2012, Draper 2012). Numerous institutions, such as World Health Organization, International Council of Nurses, International Council of Midwives and the Joint Commission on Accreditation of Healthcare Organizations, have emphasised that it should be focused on meeting individual needs through a holistic approach and that nursing care should be integrated with spiritual care (Draper 2012, McSherry & Jamieson 2011, Wu et al. 2012).

Spiritual needs and psychosocial needs are more intangible, complex and difficult to measure than physical needs (McSherry & Jamieson 2011). Individuals' easily measurable physical needs are often first addressed in health care; however, patients' spiritual needs might be overlooked (Ergul & Temel 2004, Ergul & Temel 2007, Govier 2000, Pesut & Sawatzky 2005, Yilmaz & Okyay 2009). The subjectivity of spirituality and the complex structure of health care practices and nursing care make it difficult to understand this concept (McSherry & Jamieson 2011). Therefore, nurses should view spirituality not merely as a task but as a part of nursing practices (Swinton & Pattison 2010) and should provide the necessary spiritual care to maximise the physical, emotional, social and spiritual welfare of individuals (Wailand 2010). The inclusion of spiritual care in nursing practices (Meehan 2012) has been observed to contribute to the professionalisation of nursing (McSherry & Jamieson 2011, Wu et al. 2012). Incorporating spiritual care into holistic nursing care practices and making it a policy and standard will prompt interpersonal communication, interactions and the exchange of thoughts (Battey 2012).

Nurses' perceptions of spirituality directly affect care (Swinton & Pattison 2010, Draper 2012). The topic of spiritual care in nursing is not fully recognised in Turkey, and studies on this topic are rather limited (Ergul & Temel 2004, Kostak 2007, Ozbasaran et al. 2011, Yilmaz & Okyay 2009). In a study conducted in Turkey, is stated that nurses understand the spirituality; however, do not reflect it into their nursing practices but confine spirituality to their religious beliefs and practices (Ergul & Temel 2007, Ozbasaran et al. 2011, Yilmaz & Okyay 2009). In the research conducted by Ozbasaran et al. it is reported that 83.7% of nurses accept spirituality as religious belief and 89.7% of them believe in destiny. The Turkish population is predominantly Muslim (99%) (Icduygu, Toktas & Soner 2008). Belief in destiny is common in Islamic culture. Faith is considered as one of the main principles of Islam "Destiny" has meanings of appreciation, power, afford, determination of the shape and nature of something according to the divine (Aktepe 2012). It is also regarded as the arcona of God (Gunduz 1998, Sinanoğlu 2002). Destiny means a pre-determined or pre-destinated life for a person controlled by the divine (Gunduz 1998). "Muslims who believe in destiny think that many things ranging from small problems to big catastrophes are a kind of test for them, and religion has a big role in coping with problems (Horozcu 2010). Turkish Muslim people mostly perform reading prayers, praying and fasting reading the Koran for spiritual satisfaction (Horozcu 2010, Icduygu, Toktas & Soner 2008). Spirituality and religiosity are important features of cultural identity in Turkey (Ozbasaran et al. 2011). Many patients stated that spirituality plays an important role in their life, and they believe that nursing care must be considered as part of the spiritual care (Wong, Lee & Lee 2008). Most of the nurses is not clear how the understanding of How spirituality is understand and used at patient care is not clear for must nurses (Ozbasaran et al 2011, Wu et al. 2012, Yilmaz & Okyay 2009).

Aim

This study is aimed to explore Turkish midwives and nurses' perceptions of spirituality and spiritual care and to investigate the relationship between their perceptions and some variables.

Materials and Methods

This descriptive survey study was organized in a university hospitals in Edirne, which is the European parts and northwestern of Turkey. A total of 396 nurses and midwives work at the Health Practice and Research Center of an University in Turkey. The study sample was composed of midwives and nurses (n = 243;

61.4%) working at the Health Practice and Research Center of an University.

Data collection tools

The data were collected during the period between 15 April 2013 and 15 June 2013 through face-to-face interviews in which participants completed the personal information form and the Spirituality and Spiritual Care Rating Scale (SSCRS). The information form was designed by the researchers in line with the literature (Biro 2012, Ergul & Temel, 2004, Ergul & Temel 2007, McSherry & Ross 2002a, McSherry & Jamieson 2011, Wu et al. 2012, Yilmaz & Okyay 2009). The form consisted 12 questions intended to collect information about nurses' and midwives' socio-demographic characteristics (age, gender, marital status, education level, the programme from which they graduated) and working life (their clinic of employment, working years, reception of information about spiritual care and provision of spiritual care).

Ergul and Temel (2007) validated and tested the reliability of the SSCRS developed by McSherry et al. (2002b) for Turkey. The scale has 17 items rated on a 5-point Likert scale and divided into 3 sub-dimensions: spirituality and spiritual care (7 items), religiosity (4 items) and personal care (4 items). The third and fifth items of the scale are not included in a sub-dimension. The lowest score that can be obtained on the scale is 17, while the highest is 85. High total points and mean item scores close to 5 indicate a high perception of spirituality and spiritual care concepts.

The Cronbach's alpha coefficient of the scale was 0.64 in the original study (McSherry & Ross 2002b), while Ergul and Temel (2007) found a Cronbach's alpha coefficient of 0.76 in the reliability study in Turkey. The Cronbach alpha's coefficient in this study was 0.74.

Ethical permission

The Non-invasive Clinic Research Ethics Board of the Medical Faculty Deanship of an University issued permission for this study dated 27 March 2013 (Reference no: 07/07).

Written permission was also received from the institution at which study was conducted. The purpose of the study was explained to the participating nurses and midwives, and their verbal consent was secured. Participants were instructed not write their names on the data collection form and were informed that the acquired data would be used for scientific purposes.

Data analysis

Data were expressed as a mean ± standard deviation or number (percentage). The normality distribution of the variables was tested with a sample Kolmogorov–Smirnov test. Differences between groups (the programme from which they graduated: nursing or midwifery; hearing about spiritual care concepts: yes, no: reception of information about spiritual care: yes, no: provision of spiritual care; yes, no) were assessed with a *t* test and Mann–Whitney *u* test. Statistical differences in SSCRS scores according to education level (medical vocational high school, associate degree, bachelor degree, postgraduate degree) were assessed with a Kruskal-Wallis test.

A Bonferroni test was used for multiple comparisons when significant results were found. The relationships between socio-demographic characteristics (age, working years) and SSCRS scores were analysed with Spearman's rank correlation coefficients.

Statistica 7.0 (StatSoft Inc., Tulsa, OK, USA) statistical software was used for statistical analysis. A p value of < 0.05 was considered statistically significant.

Results

The average age of the nurses and midwives participating in the study was 31.04±6.37 (minimum: 20, maximum: 56), and all were female.

Among participants, 83.5% (n = 203) were nurses, 16.5% (n = 40) were midwives, and 37.9% (n=92) were associate degrees.

The average working years of nurses and midwives was 9.70±6.98, and 45.7% worked in surgical clinics, while 28% worked in internal disease clinics. As well, 62.6% of participants reported that they heard of spiritual care concepts, 28.8% that they received information about spiritual care, and 46.5% that they gave spiritual care to patients (Table 1).

Participants' graduation programme (midwife or nurse), education level and clinic of employment did not affect SSCRS scores ($p > 0.05$) (Table 1).

Table 1. Comparison of SSCRS and sub-dimension mean scores by characteristics of nurses and midwives (n = 243)

Independent variables (n; %)	Spirituality and spiritual care Mean ± SD*	Religiosity Mean ± SD*	Personal care Mean ± SD*	Total Mean ± SD*
Programme of graduation				
Nurse (203;83.5)	26.10±3.75	14.04±2.42	14.00±2.25	63.06±6.66
Midwife (40;16.5)	26.67±4.86	13.70±2.72	13.60±2.39	62.90±7.69
t	-0.828**	0.814**	1.028**	0.143**
p	0.409	0.753	0.305	0.887
Education level				
Medical Vocational School (50;20.6)	26.14±3.74	13.58±2.55	13.64±2.59	62.30±6.82
Associate degree (92,37.9)	25.75±4.45	14.13±2.31	13.69±2.26	62.71±7.15
Bachelor degree (87;35.8)	26.77±3.53	13.96±2.55	14.37±2.06	63.77±6.68
Postgraduate (14;5.7)	25.85±3.57	14.71±2.75	13.85±2.17	63.28±5.68
χ^2	3.401***	2.739***	4.376***	2.293***
p	0.334	0.434	0.224	0.514
Clinic of employment				
Surgical (111;45.7)	26.10±3.76	14.01±2.41	13.70±2.14	62.52±6.68
Internal diseases (68;28.0)	26.38±3.78	13.66±2.14	14.22±2.10	62.98±6.18
Intensive care (29;11.9)	27.31±4.00	14.06±2.78	14.44±1.93	65.37±6.28
Emergency (27;11.1)	25.07±4.79	14.18±3.21	13.77±3.41	62.55±8.98
Other (e.g. policlinic, laboratory) (8 ;3.3)	25.75±4.52	15.50±1.92	13.50±1.77	63.87±7.62
χ^2	4.984	5.421	6.548	4.360
P	0.289	0.247	0.162	0.359
Heard of spiritual care				
Yes (152;62.6)	27.15±3.61	14.24±2.54	14.48±2.00	64.91±6.32
No (91;37.4)	24.60±3.99	13.57±2.31	13.02±2.41	59.91±6.50
t	5.119**	2.060**	5.100**	5.901** <
p	**< 0.001**	**0.041**	**< 0.001**	**0.001**
Reception of information about spiritual care				
Yes (70;28.8)	28.34±2.97	14.45±2.79	15.00±1.85	66.97±5.74
No (173;71.2)	25.33±3.98	13.80±2.32	13.50±2.29	61.45±6.59
t	5.708***	1.872***	4.834***	6.123*** **< 0**
p	**< 0.001**	> 0.05	**< 0.001**	**.001**
Provision of spiritual care				
Yes (113;46.5)	27.11±3.38	13.92±2.43	14.48±1.77	64.39±5.93
No (76; 31.3)	25.39±4.77	14.11±2.61	13.40±2.81	61.52±8.19
Sometimes (54;22.2)	25.42±3.41	13.94±2.47	13.53±2.13	62.33±5.99
χ^2	12.765**	0.115**	13.099**	9.632**
P	**0.002**	> 0.05	**0.001**	**0.008**

*Mean ± SD: mean ± standard deviation, ** Student- *t* test, *** KW: Kruskal Wallis variance analysis

Table 2. Spirituality and Spiritual Care Rating Scale item mean scores of nurses and midwives (n = 243)

İtems	Mean	SD*
1. I think that nurses can provide spiritual care by inviting a religious official to the hospital upon patient demand.	3.24	1.23
2. I think that nurses can provide spiritual care by acting in a compassionate, concerned, positive manner while giving care.	4.10	0.96
3. I think that spirituality is only concerned with the need to forgive and be forgiven.	3.63	0.94
4. I think that spirituality involves only going to a place of worship (e.g., a mosque, church).	4.00	0.98
5. I think that spirituality is not concerned with belief in God or a Supreme Power and worship.	3.09	1.20
6. I think that spirituality is concerned with finding meaning in the good and bad events of our lives.	3.40	0.95
7. I think that nurses can provide spiritual care by giving time to patients to support them in their time of need.	3.60	1.04
8. I think that nurses can provide spiritual care by helping patients find the meaning and causes of their illnesses.	3.65	0.92
9. I think that spirituality is concerned with having hope for life.	3.76	0.85
10. I think that spirituality is about living one's life here and now.	3.09	0.91
11. I think that nurses can provide spiritual care by giving time to listen to patients and explain and discuss their fears, worries and sorrows.	3.71	1.00
12. I think that spirituality is a unifying force which enables one to be at peace with oneself and one's environment.	3.95	0.81
13. I think that spirituality does not involve areas such as art, creativity and self-expression.	3.28	1.11
14. I think that nurses can provide spiritual care by showing respect for the privacy, dignity, religion and cultural beliefs of a patient.	4.10	0.74
15. I think that spirituality involves personal friendships and relationships.	3.48	0.93
16. I think that spirituality does not apply to those who do not have a belief in God or Supreme Power.	3.61	1.07
17. I think that spirituality is a concept that includes morality.	3.75	0.96

*Mean ± SD: mean ± standard deviation

Table 3. Spearman coefficients and significance levels (p) of the relationship of SSCRS and sub-dimension scores and the characteristics of nurses and midwives (n = 243).

Charactheristic		Spirituality and Spiritual Care	Religiosity	Personal care	Total SSCRS
Age	r_s	-0.188	0.078	-0.165	-0.121
	p	**0.003**	0.224	**0.010**	0.059
Working year	r_s	-0.161	0.050	-0.166	-0.096
	p	**0.012**	0.438	**0.010**	0.134

SSCRS: Spirituality and Spiritual Care Rating Scale, r_s : Spearman's rank correlation coefficients

The mean total SSCRS score of nurses and midwives was 63.04±6.82 (min = 42, max = 81). The mean score was 26.20±3.95 for the sub-dimension of spirituality and spiritual care, 13.93±2.27 for the sub-dimension of personal care, and 13.99±2.47 for the sub-dimension of religiosity.

Among the SSCRS item mean scores, the highest scores were recorded for the second item (4.10±0.96) ("I think that nurses can provide spiritual care by acting in a compassionate, concerned, positive manner while providing care") and the fourteenth item (4.10±0.74) ("I think that nurses can provide spiritual care by showing respect for the privacy, dignity, religion and cultural beliefs of a patient").

The following items also had high mean scores: "I think that spirituality involves only going to a place of worship (e.g., a mosque, church)" (4.00±0.98) (item 4) and "I think that spirituality is a unifying force which enables one to be at peace with oneself and one's environment" (3.95±0.81) (item 12) (Table 2).

Statistically significant differences were found in the SSCRS total and sub-dimension mean scores according to whether participants had heard of spiritual care, received information about spiritual care and provided spiritual care (Table 1). The SSCRS total mean scores of nurses and midwives indicate that those who had heard of spiritual care (t = 5.901, p< 0.001) had high sub-dimension mean scores for spirituality and spiritual care (t = 5.119, p< 0.001), religiosity (t = 2.060, p = 0.041) and personal care (t = 5.100, p< 0.001) (Table 1). Compared to those who did not receive information about spiritual care, those who received such information had high SSCPS total scores (t = 6.123, p< 0.001) and high mean sub-dimension scores for spirituality and spiritual care (t = 5.708, p< 0.001) and personal care (t = 4.834, p< 0.001) (Table 1).

There was a significant difference in the provision of spiritual care and SSCRS total mean scores (χ^2 = 9.632; p = 0.008) and the mean scores for the spirituality and spiritual care (χ^2 = 12.765; p = 0.002) and personal care (χ^2 = 13.099, p = 0.001) sub-dimensions. Advanced analysis with a Bonferroni post-hoc test found that the difference was caused by differences in whether participants provided spiritual care. As well, nurses and midwives with high spirituality and spiritual care (p = 0.009) and personal care (p = 0.004) sub-dimension mean scores also had high SSCRS total (p = 0.012) mean scores (Table 1).

A negative relationship was found between participants' ages and SSCRS spirituality and spiritual care (r = -0.188; p = 0.003) personal care (r = -0.165; p = 0.012) sub-dimension scores and between working years and spirituality and spiritual care (r = -0.161; p = 0.012) and personal care (r = -0.166; p = 0.010) sub-dimension scores (Table 3). As age and working years increased, the spirituality and spiritual care and personal

care sub-dimension scores and spirituality and spiritual care perceptions decreased.

Discussion

In this study, it was found that only 28.8% of nurses and midwives received information about spirituality and spiritual care during their education, and only 46.5% gave spiritual care to patients (Table 1). Similarly, Yilmaz and Okyay (2009) found that 34.8% of nurses received information about spirituality and spiritual care, and 70.3% and 93.4% could correctly define spirituality and spiritual care, respectively. Wu et al. (2012) found that 46.5% of nursing students received education about spirituality, and 34.4% about spiritual care. However, Tiew et al. (2013) reported that nursing students believed in spiritual care, saw it as part of holistic nursing care, and had good awareness of it, although they had not experienced spiritual care in nursing practices. In this study, the low proportion of participants receiving information about spiritual care during their education is a result of most nurses and midwives attending associate degree programmes, which in Turkey do not include spirituality as a subject. In addition, that 37.4% of nurses and midwives had not heard of the concept spiritual care is an important indicator of the lack of education on this topic. However, it is observed that the findings regarding the provision of spiritual care by nurses and midwives are similar to those found in other studies (46.5%, Table 1). In the literature, the most important causes of not providing spiritual care are time constraints and a lack of education among nurses (Baldacchino 2008, Wong et al. 2008).

Participants' SSCRS total mean score was 63.04±6.82 (min = 42, max = 81), while the item mean score was 3.40±0.97 (Table 2). In research involving nurses, Yilmaz & Okyay (2009) found a SSCRS mean score of 54.57±5.09, and Ozbasaran et al. (2011) an item mean score of 3.21±0.63. Ozbasaran et al. (2011) and Wu et al. (2012) also reported that nurses had high spirituality and spiritual awareness, but their spiritual care practices were unclear. The findings of this study also show that nurses need information about this topic. Only 28.8% of nurses and midwives had received information about spiritual care, and 37.4% had never heard of the concept of spiritual care (Table 1). These results indicate that spirituality and spiritual care topics are not understood sufficiently and that half of nurses neglected spiritual care in patient care. Performing spiritual care is left to the discretion of nurses (Wong et al. 2008), and nurses' perceptions of spirituality and providing spiritual care directly affect care (Draper 2012, Swinton & Pattison 2010). As well, the spiritual dimension of care has a clear effect on health, welfare and life quality (Coyle 2002, Ergul & Temel 2004, Hall 2006, Wallace & O'She 2007, Wong et al. 2008, Draper 2012). Patients who receive spiritual care have been reported to enjoy longer life, positive health results (Wong et al. 2008, Hussey 2009, Daaleman 2012) and good coping skills and lower levels of anxiety, depression and suicidal thoughts (Wu et al. 2012). Therefore, spiritual care is important, and nurses play a crucial role in providing spiritual care (Swinton & Pattison 2010, Draper 2012). This topic should be included in nursing education and in-service training programmes, and clinics should issue necessary regulations for nursing care to develop nurses' perceptions of spirituality and spiritual care and to translate these perceptions into nursing care.

In this study, participants had the highest SSCRS item mean scores on the second and fourteenth items, followed by the fourth and twelfth items. These items are generally related to religious, cultural and personal tolerance. According to the literature, spirituality is affected by culture, while spiritual care is affected by religious beliefs (McSherry & Ross 2002b, Baldacchino 2008). Similarly, McSherry & Jamieson (2011) also found the highest score from the fourth item. Ozbasaran et al. (2011) found that the fourteenth item returned the second highest second in a study in Turkey and reported that common cultural concepts, such as fate and the evil eye, had positive effects on spiritual care.

In the present study, nurses and midwives had high mean scores for the spirituality and spiritual care and religiosity sub-dimensions. Considering that the highest score possible for the religiosity sub-dimension is 20, this result can be interpreted to indicate that nurses and midwives attach high importance to religious dimension of spirituality. Wu et al. (2012) also found high religiosity sub-dimension mean scores among nursing students. Spiritual care includes all types of nursing care which support the religious practices, personal beliefs and values of the patient; therefore, religion constitutes a basic

component of the spirituality concept (Strang et al. 2002). Wong et al. (2008) found high religiosity sub-dimension scores but contended that spirituality should not be equated or assumed to be related only to religion. Along with the present study, the results of earlier research indicate that nurses generally have an insufficient recognition of spirituality and restrict spirituality to religious needs (Hussey 2009, McSherry & Jamieson, 2011).

In this study, nurses and midwives who received information about spirituality and spiritual care had higher spirituality and spiritual care perception levels (Table 1). Yilmaz & Okyay (2009), working in Turkey, and Wong et al. (2008), working in China, found that nurses' education level affected their spirituality perceptions; as their level of education increased, their spirituality and spiritual care perceptions changed in positively. In this study, nurses' and midwives' reception of information about spiritual care affected SSCRS scores, but strikingly, education level did not (Table 1), suggesting that topics, such as spirituality and spiritual care, were not addressed in nursing education. Yilmaz & Okyay (2009) found that 83.2% of nurses knew the importance of education in realising spiritual dimensions. These results show that sufficient education and training about spirituality and spiritual care is not delivered in nursing and midwifery education, and consequently, nursing practices do not reflect spiritual care.

As emphasised in the literature, many factors affect nurses' provision of spiritual care. However, education and nursing practices do not sufficiently address the concept of spiritualty, and intangible spiritual needs are difficult to realise. Consequently, education is important to identify and provide care for the spiritual needs of patients (Baldacchino 2006, Govier 2000, Narayanasamy & Owens 2001, Pesut & Sawatzky 2005, Wong et al. 2008, Yilmaz & Okyay 2009).

In addition, spirituality has been reported to play an important role in patients' lives, and spiritual care should be taken into account during nursing care (Vlasblom 2015). Although 77% of patients reported that spirituality was very important for them in a study, only 10%–20% of health professionals take this into account (Wong et al. 2008). The results of other and this study clearly show that training and courses about this topic should be available before and after graduation to incorporate spiritual care into health care practices.

As the age and working years of nurses and midwives increased, their perceptions of spirituality and spiritual care and personal care decreased (Table 3). Ozbasaran et al. (2011) reported that long working experience among nurses might have a negative effect on spiritual care. In contrast, several studies found that older, more experienced health care providers possessed higher spirituality and spiritual care perceptions (Cavendish et al. 2004, Ozbasaran et al. 2011, Wong et al. 2008, Yilmaz & Okyay 2009). These results can be explained by the increasing inclusion of the concept of spiritual care in nursing practices and education in recent years.

Conclusion

Although spiritual care is an important part of nursing care, the study results show that nurses and midwives have not received sufficient education and did not possess adequate information about this topic. Consequently, the spirituality of patients was neglected during care, and the provision of spiritual care was insufficient. It has been found out that receiving training about spiritual care and working year (seniority) is a determining cause among the factors affecting spiritual care practices of nurses and midwives.

Nurses/midwives who are the administrators of patient care can improve and implement spiritual care in their daily nursing practices with educational methods. Deciding on the patient's care based on the patient's needs is an extra responsibility. Pre and post-graduate training provided to nurses and midwives will contribute to improving the ability of nurses and midwives to treat patients with a holistic approach.

Training programs should include spiritual values particularly and should be ensured to be reflected in patient care. These findings will contribute to recognition of spiritual needs by nurses that are ruled out in health care systems. They will also increase the sensitivity to deliver spiritual care in nursing practices. Future research on this topic should include a larger sample groups to identify the factors affecting

the provision of spiritual care by nurses and midwives.

Acknowledgements

We thank all the nurse and midwives who participated in this study.

References

Aktepe O. (2012). The nature of predestination and the problem of its possibility of change- Kelam Araştırmaları.; 10 (2): 69-90.

Baldacchino D. (2006). Nursing competencies for spiritual care. Jurnal of Clining Nursing; 15 (7): 885-896.

Baldacchino D. (2008). Teaching on the spiritual dimension in care to undergraduate Nursing students: the content and teaching methods. Nurse Education Today; 28: 550- 562.

Battey BW. (2012). Perspectives of spiritual care for nurse managers. Journal of Nursing Management; 20: 1012–1020.

Biro AL. (2012). Creating conditions for good nursing by attending to the spiritual. Journal of Nursing Management; 20: 1002–1011.

Cavendish R. Luise B., Russo D., Mitzeliotis C, Bauer M, McPartlan Bajo MA, Calvino C, Horne K, Medefindt J. (2004). Spiritual perspectives of nurses in the United States relevant for education and practice. Western Journal of Nursing Research; 26: 196–212.

Coyle J. (2002). Spirituality and health: towards a framework for exploring the relationship between sprituality and health. Journal of Advanced Nursing; 37 (6): 589-597.

Daaleman TP. . (2012). A health services framework of spiritual care. Journal of Nursing Management; 20: 1021–1028.

Draper P. (2012). An integrative review of spiritual assessment: implications for nursing management. Journal of Nursing Management; 20: 970–980.

Dastan NB., Buzlu S. (2010). The effects of spirituality ın breast cancer patients and spiritual care. Maltepe University Journal of Nursing Science and Art; 3 (1): 73-79.

Ergul S., Temel AB. (2004). Nursing and spiritual care. Journal of Cumhuriyet University School of Nursing; 8 (1): 37-45.

Ergul S., Temel AB. (2007). Validity and reliability of 'The spirituality and spiritual care rating scale' Turkish version. Journal of Ege University School of Nursing; 23 (1): 75-87.

Govier, I. (2000). Spiritual care in nursing: a systematic approaach, Nursing Standard; (14) 17, 32-36.

Gunduz S. (1998). Dictionary of Religion and Belief). Vadi Publications. 1. Edition; page: 207.

Hall J. (2006). Spirituality at the beginning of life. Journal of Clinical Nursing; 15: 804–810.

Horozcu, U. (2010). Light on Empirical Research Relationship Religiosity and Spirituality between Mental and Physical Health, Milel ve Nihal; 7 (1), 209-240.

Hussey T. (2009). Nursing and spirituality. Nursing Philosophy; 10: 71–80.

Icduygu A, Toktas S., Soner A. (2008). The politics of population in a nation-building process: Emigration of non-Muslims from Turkey. Ethnic and Racial Studies; 31: 358–389.

Kostak MA. (2007). The spiritual dimension of nursing care. Fırat Journal of Health Services; 6: 105–115.

McSherry W., Jamieson S. (2011). An online survey of nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing; 20: 1757–1767.

McSherry W., Ross L. (2002b). Dilemmas of spiritual assessment: considerations for nursing practice. Journal of Advanced Nursing; 38 (5): 479–488.

Mcsherry W., Draper P, Kendrick D. (2002a). The construct validity of a rating scale designed to assess spirituality and spiritual care. International Journal of Nursing Studies; 39:723-734.

Meehan TC. (2012). Spirituality and spiritual care from a careful nursing perspective. Journal of Nursing Management; 20: 990–1001.

Narayanasamy A, Owens J. (2001). A Critical incident study of nurses'responses to the spiritual needs of their. Journal of Advanced Nursing. 2001; 33: 446–455.

Ozbasaran F., Ergul Ş, Temel AB Aslan GG, Coban A. (2011). Turkish nurses' perceptions of spirituality and spiritual care. Journal of Clinical Nursing; 20: 3102–3110.

Pesut B., Sawatzky R. (2005). To describe or prescribe: assumptions underlying a prescriptive nursing process approach to spiritual care. Nursing Inguiry; 13: 127-134.

Sapountzi-Krepia D., Raftopoulos V., Sgantzos M., Kotrotsiou E., Roupa-Darivaki Z.,Sotiropoulou K., Ntourou I., Dimitriadou A. (2005). Validation and test-retest reliability of the Royal Free Interview for spiritual and religious beliefs when adapted to a Greek population. Ann Gen Psychiatry; 4:4(1):6.

Sapountzi-Krepia D., Sgantzos M., Dimitriadou A., Kalofissudis I. (2003). The Greek translation and modification of the Royal Free Interview for spiritual and religious beliefs: the self-report version. ICUS NURS WEB; 14:1-13

Sinanoğlu A. (2002). The Idea of "Predestination" in Early Politisation Process of Islam. AÜİFD; 43(2): 249-276

Strang S., Strang, P. (2002). Ternestedt, M. Spiritual needs as defined by Swedish nursing staff. Journal of Clinical Nursing; 11: 48–57

Swinton J., Pattison S. (2010). Moving beyond clarity: towards a thin, vague, and useful understanding of spirituality in nursing

carenup_450 226.7 Nursing Philosophy; 11: 226–237.

Tiew LH., Creedy DK. Chan, M.F. (2013). Student nurses' perspectives of spirituality and spiritual care. Nurse Education Today. 2013; 33: 574–579.

Yilmaz M., Okyay N. (2009). Nurses' views concerning spiritual care and spirituality. Journal of Research and Development in Nursing. 2009; 3: 41–52.

Wallace M., O'She E. (2007). Perceptions of spirituality and spiritual care among older nursing home residents at the end of life. Holistic Nursing Practice; 21 (6): 285-289.

Weiland SA. Integrating spirituality into critical care an apn perspective using Roy's adaptation model. Crit Care Nurs Q 2010; 33(3):282–291.

Vlasblom JP., Steen JT., Walton MN., Jochemsen H. (2015). Effects of nurses' screening of spiritual needs of hospitalized patients on consultation and perceived nurses' support and patients' spiritual well-being. Holist Nurs Pract 2015;29(6):346–356.

Wong KF., Lee LYK., Lee JKL. (2008). Hong Kong enrolled nurses' perceptions of spirituality and spiritual care. International Nursing Review; 55: 333–340.

Wu LF., Liao YC., Yeh DC. (2012). Nursing student perceptions of spirituality and spiritual Care. Journal of Nursing Research; 20(3): 219-226.