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# An Exploratory Study of Spirituality and Spiritual Care Among Malaysian Nurses

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**Abstract** The increasing evidence that spirituality is a critical component for promoting health and well-being has made spirituality more significant to nursing practice. However, although nurses' perceptions of spirituality have been studied in western countries, there has been little research on this topic in Southeast Asian countries where religions other than Christianity predominate. This study explores Malaysian nurses' perceptions of spirituality and spiritual care and examines associations between socio-demographics and their perceptions. The Malaysian Nurse Forum Facebook closed group was used for data collection with 208 completed the online survey. The participants considered that spirituality is a fundamental aspect of nursing. Nonetheless, half of the respondents were uncertain regarding the use of the spiritual dimension for individuals with no religious affiliation. Significant differences were found between educational levels in mean scores for spirituality and spiritual care. There was also a positive relationship between perception of spirituality and spiritual care among the respondents. Despite the positive perceptions of nurses of spirituality in nursing care, the vast majority of nurses felt that they required more education and training relating to spiritual aspects of care, delivered within the appropriate cultural context.

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## Introduction

The issue of spirituality has come to the attention of the public and health professionals in the past several decades. With the emergence of a new century, the topic of spirituality gained a place in the media and attracted more dialogue in education, politics and the workplace (Young and Koopsen 2011). Nowadays, the topic of spirituality is broadly recognised by healthcare providers and understanding the spiritual and religious beliefs and practices of patients is seen as essential (Burkhardt and Nagai-Jacobson 2013; Carson and Stoll 2008). The increasing evidence that spirituality is a critical component for promoting health and well-being has made spirituality more significant (Burkhardt and Nagai-Jacobson 2013). However, caregivers frequently avoid exploring the spiritual dimensions of health with their patients, even though best practice in the provision of culturally safe spiritual care has been identified by a substantial body of research literature (Molzahn and Sheilds 2008; Pinto et al. 2008; Plotnikoff 2007). On the other hand, the lack of a clear definition or concise guidelines, together with limited training and professional development for healthcare providers in relation to spiritual dimensions, has contributed to the neglect of the spiritual aspect of care in patients (Burkhardt and Nagai-Jacobson 2013).

## Nurses' Perceptions of Spirituality

There is a diversity of perceptions among nurses in relation to spirituality. Nurses recognised spirituality as a concept that was universal and relevant to all, and not only limited to religious beliefs and practices (McSherry and Jamieson 2011). They also perceived that spirituality encompassed aspects of life which bring meaning, purpose and fulfilment. In several studies, elements such as relationships, personal beliefs and morals appeared to provide an understanding relating to the participants' definitions of spirituality (McSherry and Jamieson 2011; Ozbasaran et al. 2011; Wong et al. 2008; Wu and Lin 2011).

The concept of spirituality can be explained as "an umbrella term" (McSherry and Jamieson 2011, p. 1761) because of the variety of personal meanings, connections and explanations that people use to describe and make clear their understanding of this concept. McSherry and Cash (2004) suggest a classification to explain the wide range of opinions that may be related to spirituality. For instance, religiosity and faith may be the sole influence on spirituality of some individuals, while for others spirituality is more associated with personal philosophy or individual attitudes to life and beliefs. The various approaches to spirituality highlight that this concept is not simply about people with a religious affiliation and those without, because spirituality is a whole and comprehensive concept. In addition, anything associated with "spiritual is always viewed as morally or aesthetically valuable" (Hussey 2009, p. 73).

### Spiritual Care in Nursing

Spiritual care in nursing is integral to holistic health promotion (Carr 2010). Studies by healthcare researchers have shown that there is an association between mind, body,

wellness and individual spirituality or religious practices (Han and Richardson 2010; Koenig and Vaillant 2009). Mutual benefits, such as inner peace, may be experienced by nurses and patients when nurses provide spiritual care according to patients' needs (Penman et al. 2009). The application of spiritual and religious resources to patients and families gives them strength during a time of intense difficulty (Friedman et al. 2010).

A study by Gebhardt (2008) found that nurses in a rehabilitation area felt that other nurses may not view acts they do as spiritual care, if they do not self-identify those actions as spiritual care. The nurses also stated that they feel more comfortable in providing spiritual care when the care is provided repeatedly and their own sense of spirituality is strong. Nevertheless, it appears that there is a contradiction for some nurses between personal values and professional responsibilities. The clarification between professional and personal boundaries is critical in order to enable nurses to be more competent and confident in providing spiritual care (McSherry and Jamieson 2013).

On the other hand, Christensen and Turner (2008) concluded that there is a problem with incorporating spiritual care in daily nursing practice within the culture of Danish nursing. Their study showed that, even though the nurses were very committed to providing spiritual care to their patients, they found it complex and hard work. The authors consider that a feeling of embarrassment may be one possible interpretation of this condition (Christensen and Turner 2008). Another possible explanation is that nurses are uncertain about exposing themselves or they are very careful to avoid unintentionally influencing patients with their own beliefs (Christensen and Turner 2008). This is consistent with a study conducted with hospice nurses (Belcher and Griffiths 2005), which found that the nurses were very cautious about expressing their spirituality in the work environment.

## Spirituality and Spiritual Care Education

Providing spiritual care education to nurses can facilitate their understanding by updating their knowledge and increasing self-awareness of their own spirituality and nursing care (Baldacchino 2011). Many studies suggest that spiritual content needs to be incorporated in nursing education and specific training is required for nurses in order to prepare them to provide spiritual care competently (Cooper et al. 2013; McSherry and Jamieson 2011; Timmins 2014). O'Shea et al. (2011) suggest that providing training sessions on spirituality and spiritual care for nurses has a positive effect on their perceptions of spiritual care. Hence, nurses are required to gain adequate education and information regarding their patients' traditions and practices in order to offer culturally sensitive religious and spiritual care.

Spiritual elements are complementary to nursing care. Lack of spiritual education among nurses is one reason for the inadequate provision of spiritual care (Ronaldson et al. 2012). Education is necessary to increase nurses' awareness of the multiplicity of cultures and religions and to enable the spiritual needs of patients to be met (Lundberg and Kerdonfag 2010). Therefore, spirituality needs to be addressed within nursing curricula to ensure that the practice of spiritual care is not neglected (Ellis and Narayanasamy 2009). A survey by McSherry and Jamieson (2011) of nurses' perceptions of spirituality and spiritual care showed that 79% acknowledged that nurses do not obtain enough education and training in spirituality. In this survey, the disagreement with the statement 'spirituality and spiritual care should not be included in nursing curricula programs' was about 80%. This is an indication that nurses feel that the integration of these concepts in professional education is very important (McSherry and Jamieson 2011). By understanding these needs,

opportunities may be created for nurses to discuss elements of spirituality and apply the knowledge through actions (Gallison et al. 2013).

Based on the literature review, most studies have been conducted in western countries with participants predominately by Christians of different denominations, while there have also been some studies among Muslim and Buddhist populations. According to Clarke (2009), sources used in spirituality and nursing literature are "selective in that Buddhism or Hinduism may be referred to very occasionally but Islam is rarely mentioned" (p. 1668). In terms of culture, mostly the participants of the studies have the same cultural background. The multiplicity of the Malaysian population with minimal cultural assimilation of ethnic minorities may provide different perspectives of spirituality and spiritual care in nursing. In addition, nurses' perceptions of spirituality and spiritual care in the Malaysian context have not been widely researched. Therefore, this study is relevant to meeting the needs of Malaysian society in relation to spiritual care and may contribute knowledge of the spiritual dimension in nursing.

### Aims of Study

The overarching aim of this study was to explore Malaysian nurses' perceptions of spirituality and spiritual care. The specific objectives were (1) to describe Malaysian nurses' perceptions of spirituality and spiritual care; (2) to identify the relationship between perceptions of spirituality and spiritual care; (3) to identify associations between demographics and nurses' perceptions of spirituality and spiritual care.

## Methods

### Design and Setting

A descriptive cross-sectional study design was selected to investigate nurses' perceptions of spirituality and spiritual care in this study. An online survey, using the Qualtrics software, was administered to a chosen sample from a specific population in Malaysia through a large internet-based disciplinary group. Malaysia is a country in Southeast Asia where 97.4% of the population practice some form of religion; 61.3% identify as Muslim, 19.8% as Buddhist, 6.3% as Hindu, 9.2% as Christians and 0.8% as atheist (IndexMundi 2014).

### Sample

This study used a total population sampling method to recruit the participants, as they have a particular set of characteristics. Participation in this survey was open to all nurses in Malaysia registered as members of the Facebook closed group. This supporting group is a place for nurses to build networks, share and learn from their peers. The group membership was 14,500 at the time of the study. The sample size required to provide a representative sample, considering a confidence level of 95% and a margin of error of 5%, was calculated at 377 (Raosoft 2004). An invitation to participate, including information about the study and a link to the electronic survey, was placed on the Facebook page. Nurses who responded constituted a convenience sample.

## Instrument

The Spirituality and Spiritual Care Rating Scale (SSCRS) developed by McSherry et al. (2002) was adopted to measure the nurses' perceptions of spirituality and the provision of spiritual care (see electronic supplementary material). The SSCRS was chosen because over 42 different studies in 11 countries have used this instrument (McSherry and Jamieson 2011). The questionnaire includes demographic data such as gender, age, educational background, clinical experience, ward discipline, religion and whether the respondent received spiritual care lessons during nurse training and spiritual care continuing education.

The SSCRS consists of 17 statements categorised under two parts: spirituality (11 items) and spiritual care (6 items,) (McSherry et al. 2002). In order to prevent response bias, the original authors organised the questions in the scale randomly. Five-point Likert-type scales are used for rating each statement with scores of 1 (strongly disagree), 2 (disagree), 3 (uncertain), 4 (agree) and 5 (strongly agree).

The acceptable values of alpha for the internal consistency reliability of the items range from 0.70 to 0.95 (Tavakol et al. 2011). Originally, the 17-item SSCRS established a Cronbach's alpha coefficient of 0.64, which is a reasonable level of internal consistency reliability (McSherry et al. 2002). Approval was obtained from the authors of the original study to use the instrument for this study.

The overall questionnaire was first designed in English and the internal reliability was established. However, because the present study was conducted among Malaysian nurses, the questionnaire was translated into Malay by the researcher to enable participants to answer the questionnaire. A translation/back-translation process was undertaken by one researcher and a language expert, to confirm the questionnaire translation accuracy and to ensure the original meaning of each item was retained. The translated Malay questionnaire was subsequently reviewed by other nursing lecturers from Malaysia to improve the language accuracy of the items for better understanding if necessary. The Malaysian version was checked and back-translated by a Malay PhD holder in English as an International Language who graduated from an English-speaking country and is a permanent resident in Australia. The researcher and one nursing lecturer from Malaysia compared the back-translated English questionnaire with the original version of the questionnaire to confirm its accuracy. The translation process was conducted thoroughly to ensure the original meaning of each item was retained. As the original questionnaire had been modified, a pilot study using the translated SSCRS with the demographic questions was carried out. Overall, the respondents were able to understand and answer the questionnaire for both languages.

## Ethical Considerations

Approval to conduct the study was obtained from the Monash University Human Research Ethics Committee and the Economic Planning Unit in Malaysia. Participants were informed of the purpose and procedure of the study, including its voluntary nature. Consent to participate was implied by completion and submission of the online survey. Participation was anonymous.

### Data Analysis

The data were analysed using IBM SPSS Statistics version 22. Descriptive statistics were generated for the demographic variables and for the individual items on the SSCRS. Positively worded items in the SSCRS were scored 1–5, respectively, while the negative statements were scored in reverse manner. The scores of the individual items that comprised the subscales spirituality and spiritual care were then totalled to provide overall scores for each variable. Higher scores indicate a strong perception of spirituality and spiritual care. The potential range for spirituality was 11–55, while for spiritual care the potential range was 6–30. Associations between the subscale scores and demographic data were investigated using t tests and analysis of variance (ANOVA) for nominal or ordinal level data and Pearson correlation for continuous data. The scores for the two subscales were compared using correlation. A $p < 0.05$ was considered significant.

## Results

A total of 208 completed questionnaires were received, of which 160 were in English and 48 in Malay.

### Internal Consistency

Cronbach's alpha was calculated for the overall SSCRS tool and for each of the subscales Spirituality and Spiritual Care for both the Malay and English versions. For the Malay version, Cronbach's alpha values were: 0.857 (full scale); 0.83 (Spirituality); and 0.702 (Spiritual Care). For the English version, the values were: 0.803 (full scale); 0.652 (Spirituality); and 0.78 (Spiritual Care). The Cronbach's alpha value for the spirituality scale was slightly lower than the acceptable value. This result indicates the need to improve the reliability of the spirituality scale prior to conducting a further research study.

### Demographic Data

A descriptive analysis of participants' demographic data is presented in Table 1. The vast majority of participants were female (80.3%), of Malay ethnicity (89.9%) and of the Islam faith (89.9%). Most participants were aged between 21 and 30 years (57.2%) and had less than 10 years' clinical experience (65.9%) with Diploma as their highest educational level (52.9%). The vast majority were actively involved in religion (91.8%).

The responses to the questions related to education on spirituality and spiritual care indicated that the majority of participants ($n$ = 128; 61.5%) received education on spiritual care during their initial training/study. In contrast, 165 (79.3%) received no continuing education on spiritual care. The majority ($n$ = 176; 84.6%) felt that they had received insufficient training or education on spiritual care.

### Nurses' Perceptions of Spirituality and Spiritual Care

Frequencies of responses to the individual items on the SSCRS are shown in the electronic supplementary material. The mean (SD) scores for the spirituality subscale were 42.43 (4.67) and for the spiritual care subscale were 25.28 (3.15). The majority of respondents

**Table 1** Demographics of participants

| Variables | *N* (%) |
|---|---|
| Gender (*N* = 207) | |
| Female | 167 (80.3) |
| Male | 40 (19.3) |
| *Age (*N* = 207) | |
| 21–30 | 119 (57.2) |
| 31–40 | 61 (29.3) |
| 41–50 | 23 (11.1) |
| > 50 | 4 (1.9) |
| | **M* = 31.35 (SD = 7.188) |
| Educational background (*N* = 207) | |
| Doctor of Philosophy | 3 (1.4) |
| Master | 22 (10.6) |
| Bachelor | 72 (34.6) |
| Diploma | 110 (52.9) |
| *Years of clinical experience (*N* = 187) | |
| 0–10 | 137 (65.9) |
| > 10 | 50 (24.0) |
| | **M* = 7.757 (SD = 6.173) |
| Ethnicity (*N* = 207) | |
| Malay | 187 (89.9) |
| Chinese | 12 (5.8) |
| Indian | 4 (1.9) |
| Indigenous | 4 (1.9) |
| Religious affiliation (*N* = 207) | |
| Islam | 187 (89.9) |
| Buddha | 7 (3.4) |
| Hindu | 3 (1.4) |
| Christian | 9 (4.3) |
| Freethinker | 1 (0.5) |
| Actively involved in religion (*N* = 208) | |
| Yes | 191 (91.8) |
| No | 17 (8.2) |

agreed or strongly agreed that spirituality includes people's morals (89.0%), and a sense of hope in life (87.5%), is a unifying force which enables one to be at peace with oneself and the world (85.6%), is concerned with a need to forgive and to be forgiven (84.2%), concerns how one conducts one's life here and now (79.3%), involves personal friendships and relationships (77.0%), and is about finding meaning in the good and bad events of life (75.5%). The majority disagreed that it involved only attending a place of worship (89.5%), but also disagreed that it is not concerned with belief in a God or Supreme-being (76.5%). They were more divided on whether spirituality includes art, creativity and self-expression (51.5% indicating it does) and whether it applies to atheists or agnostics (59.1% recording 'uncertain').

The majority of participants agreed or strongly agreed with all items on the Spiritual Care subscale, indicating their belief that spiritual care is not only concerned with arranging contact with religious leaders. Showing respect and concern, communicating effectively and giving support and reassurance were all identified as a means of providing spiritual care. The lowest scoring item concerned enabling patients to find meaning and purpose in their illness, with 24.5% either unsure or disagreeing that nurses could provide spiritual care in this way.

## Relationships of Independent Variables with SSCRS

The result of correlation between nurses' perceptions of spirituality and spiritual care; age and nurses' perception of spirituality and spiritual care; years of clinical experience and nurses' perception of spirituality and spiritual care are illustrated in Table 2. The result indicates a moderate positive correlation between nurses' perceptions of spirituality and spiritual care. An increase in perception of spirituality is correlated with an increase in perception of spiritual care. However, there was no correlation between age and clinical experience with either spirituality or spiritual care.

## The Comparison of Demographic Data and Nurses' Perceptions of Spirituality and Spiritual Care

### *Educational Background*

The results of the analysis of variance presented in Table 3 show that the participants' educational background was associated with perceptions of both spirituality and spiritual care. Post hoc analysis (Tukey's test) found a significant difference in the Spiritual Care scores between Master and Diploma ($p = 0.004$). However, no statistically significant differences were found in the between-group comparisons for Spirituality; a non-significant trend was observed only in the difference between Master's and Diploma level ($p = 0.08$).

### *Ethnicity and Religion*

Table 4 shows the mean scores recorded for spirituality and spiritual care according to ethnic background and religious affiliation. No associations were found between either of the outcome variables and either ethnicity or religion. Similarly, there were no significant differences between participants who actively practised a religion and those who did not in

**Table 2** The relationship between perception of spirituality and spiritual care

| Variables | *r* | *p* |
|---|---|---|
| Nurses' perceptions of spirituality and spiritual care | 0.554 | 0.001 |
| Age and nurses' perception of spirituality | − 0.075 | 0.281 |
| Age and nurses' perception of spiritual care | 0.045 | 0.515 |
| Years of clinical experience and nurses' perception of spirituality | − 0.069 | 0.322 |
| Years of clinical experience and nurses' perception of spiritual care | − 0.013 | 0.855 |

**Table 3** Spiritual care and spirituality score by educational background

| Highest education level achieved | *N* (%) | Spirituality Mean (*SD*) | *F* | *p** | Spiritual Care Mean (*SD*) | *F* | *p** |
|---|---|---|---|---|---|---|---|
| PhD | 3 (1.4) | 40.33 (3.06) | 2.662 | 0.049 | 27.00 (2.00) | 5.024 | 0.002 |
| Master | 22 (10.6) | 44.32 (4.09)[‡] | | | 26.86 (2.57)[†] | | |
| Bachelor | 72 (34.6) | 43.01 (4.82) | | | 25.58 (3.56) | | |
| Diploma | 110 (52.9) | 41.73 (4.61)[‡] | | | 24.74 (2.88)[†] | | |

*One-way ANOVA

[†]Significant difference on post hoc analysis

[‡]Non-significant trend on post hoc analysis

**Table 4** Spirituality and spiritual care score by ethnicity and religion

| Ethnicity/ Religion | *N* (%) | Spirituality Mean (*SD*) | *F* | *p** | Spiritual Care Mean (*SD*) | *F* | *p** |
|---|---|---|---|---|---|---|---|
| Malay | 187 (89.9) | 42.47 (4.65) | 0.163 | 0.957 | 25.34 (2.91) | 0.548 | 0.701 |
| Chinese | 12 (5.8) | 41.67 (4.27) | | | 25.75 (2.18) | | |
| Indian | 4 (1.9) | 42.00 (.000) | | | 26.33 (2.52) | | |
| Indigenous (*N* = 207) | 4 (1.9) | 42.50 (9.33) | | | 21.25 (10.50) | | |
| Islam | 187 (89.9) | 42.47 (4.65) | 0.496 | 0.739 | 25.34 (2.91) | 0.320 | 0.865 |
| Buddhist | 7 (3.4) | 40.29 (3.35) | | | 25.57 (2.07) | | |
| Hindu | 3 (1.4) | 42.00 (.00) | | | 26.33 (2.52) | | |
| Christianity | 9 (4.3) | 43.11 (6.75) | | | 23.89 (7.13) | | |
| Freethinker (*N* = 207) | 1 (0.5) | 45.00 (–) | | | 23.00 (–) | | |

*One-way ANOVA

the mean scores for spirituality (42.43 vs 42.47; $p = 0.894$) or in the mean scores for spiritual care (25.27 vs 25.47; $p = 0.894$).

### *Spirituality and Spiritual Care Score by Spiritual Education*

The statistical analysis information between spirituality and spiritual care score with education on spiritual care is presented in Table 5. This topic contained three variables: receiving spiritual care lessons during nurse training/study, continuing education in spiritual care and the sufficiency of any training. No significant differences were found; however, there was a non-significant trend in the association between spirituality and continuing education, with those who had received continuing education scoring slightly higher than those who had not.

**Table 5** Spirituality and Spiritual Care score by education on spiritual care

| Variables | | *N* (%) | | Mean (SD) | *t* | *p* value |
|---|---|---|---|---|---|---|
| Received education on spiritual care during nurse training/study | Yes | 128 (61.5) | Spirituality | 42.40 (5.02) | − 0.134 | 0.894 |
| | No | 80 (38.5) | | 42.49 (4.06) | | |
| | | | Spiritual Care | 25.11 (3.50) | − 0.713 | 0.477 |
| | | | | 25.56 (2.50) | | |
| Received continuing education on spiritual care | Yes | 128 (61.5) | Spirituality | 43.72 (4.17) | 1.889 | 0.060 |
| | No | 80 (38.5) | | 42.16 (4.74) | | |
| | | | Spiritual Care | 25.92 (2.25) | 1.340 | 0.182 |
| | | | | 25.30 (2.64) | | |
| Feel that sufficient training on spiritual care was received | Yes | 128 (61.5) | Spirituality | 42.13 (4.90) | − 0.405 | 0.686 |
| | No | 80 (38.5) | | 42.49 (4.63) | | |
| | | | Spiritual Care | 25.00 (4.27) | − 0.056 | 0.955 |
| | | | | 25.33 (2.91) | | |

## Discussion

This is the first study to our knowledge to explore the perceptions of nurses in Malaysia towards spirituality and spiritual care. We found that majority of nurses scored relatively high on their perceptions of spirituality and spiritual care, indicating a satisfactory response. The findings of the present study are consistent with those of previous studies using the same instrument, in which the participants' scores were greater than the mid-point score. This indicates that the participants in a number of studies agree with the fundamental aspects of spirituality and spiritual care of the rating scale (Cetinkaya et al. 2013; McSherry and Jamieson 2011; Wong et al. 2008).

In this study, Malay Muslims constituted about 90% of the participants, for whom the Islamic religion has a strong influence in shaping their culture (Haque and Masuan 2002) and spiritual beliefs (Rassool 2000). These beliefs may well represent mutual acceptance of spirituality and religion. In other words, the significant fundamental teaching of monotheistic Islam—Tawheed, or belief in the oneness of God—is the basis of the Muslim way of life (Rassool 2000). This is explained in the holy Qur'an (Ar-Rūm 30:30), as being inclined towards transcendence, which is called "fitrah", a predisposition in humans to worship One God as the source of spiritual and moral development (Sachedina 2012). From the Islamic perspective, the concept of religion is embedded in the umbrella of spirituality (Rassool 2000). Spirituality exists with religious beliefs and practices, and religion guides the spiritual path for salvation and a way of life (Rassool 2000). Therefore, there is no discrepancy between religion and spirituality for Muslims.

The vast majority of participants in this study were also actively involved in religion (91.8%). This may be because the greatest number was Muslim and religion represents an essential sociocultural aspect of their daily lives (Pope et al. 2002). However, this figure is slightly higher than the proportion of Muslim participants, which suggests active religious involvement by participants from other persuasions such as Buddhism, Christianity and Hinduism. A limitation of this question was how participants interpreted the statement

"actively involved in religion". Extended questions about the frequency and types of religious practice would have been beneficial.

Uncertainty is also apparent among the participants in this study concerning whether spirituality applies to non-religious individuals such as atheists and agnostics. This implies that respondents find difficulty in distinguishing between spirituality and religion (Wong et al. 2008) and tend to associate these two concepts (Chan 2009). This may be associated with the vast majority of Malaysians, who perceive that every person should have faith in the existence of God (Kasmo et al. 2015). This is portrayed in this study, as most participants disagree with the statement that spirituality has no relation with the belief and faith in a Supreme-being or God. Therefore, in answering this question they are unsure whether spirituality can apply to the groups of people who have no faith in a Supreme-being or God.

In the SSCRS, six items are included to explore the perceptions of several aspects of spiritual care. They indicate that nurses can provide spiritual care because it is a fundamental aspect of nursing care and may be identical with what is called psychosocial care in the literature (McSherry and Jamieson 2011; Tiew et al. 2013). The findings support the statement that spiritual care emphasises personal caring qualities and characteristic of the nurse while communicating and interacting with patients, such as "showing care, compassion, cheerfulness and kindness" (McSherry and Jamieson 2011, p. 1761). A considerable proportion of the participants agreed that integral aspects of spiritual care are respect for privacy and dignity and supporting the culture and beliefs of individual patients. Most respondents were aware of the need to refer and involve the patients' own religious/spiritual leader. This implies that the provision of spiritual care involves other professionals such as chaplains and is not dominated by nurses (McSherry and Jamieson 2011).

Perceptions among individuals can vary widely, even though they are exposed to the same reality. The study findings show that there is a moderate, positive correlation between nurses' perceptions of spirituality and spiritual care. This result indicates that the more spiritual the nurses perceive themselves, the more disposed they are to provide spiritual care. The consciousness of nurses of their own spirituality as well as that of their patients enables them to provide spiritual care (Ellis and Narayanasamy 2009).

Among the nine demographic variables, educational background was the only one to be associated with perceptions of spirituality and spiritual care. This demonstrated that education has positive effects on nurses' perceptions of providing spiritual care (O'Shea et al. 2011). However, in relation to the spirituality mean score, the difference between groups in educational background was not significant, according to the post hoc test results. This discrepancy may be due to inadequate sample size.

On the other hand, for the spiritual care rating scale, the mean score showed a significant difference between Masters and diploma qualifications, in that Masters graduates have higher mean scores than diploma holders. Similarly, studies conducted previously indicate that there is a significant difference between spiritual care mean score and level of education, and those with the highest qualifications had the highest scores (Ozbasaran et al. 2011; Ronaldson et al. 2012). The development of nurses' conception of nursing practice may consistently happen with the acquisition of knowledge (Löfmark and Wikblad 2001; Welch et al. 2001), especially skills related to encounters of issues related to spiritual care (Wong et al. 2008).

Continuing education and sufficient training are critical for the professional development of nurses. The findings indicate that the majority of the participants had not received continuing education relating to spiritual care and they felt insufficiently trained concerning spiritual care, despite all the recent interest in the spiritual dimensions of nursing in

Malaysia. This is consistent with many previous studies that indicate the lack of spiritual education in nursing (Balboni et al. 2014; Cetinkaya et al. 2013; Cooper et al. 2013; Gallison et al. 2013; Keall et al. 2014; Lundberg and Kerdonfag 2010).

Furthermore, participants who received continuing education in this study obtained higher scores than others who did not receive continuing education. Nonetheless, most participants reported that they received education on spiritual care during their first nursing training or study. However, it is not clear to what extent their undergraduate education prepared them to provide spiritual care and the lack of appropriate teaching methodology and the contents in spiritual education (Timmins et al. 2015).

Research suggests that integrating spiritual education in undergraduate nursing curricula is integral for the development of the students and their spiritual awareness (Baldacchino 2006; Chan et al. 2006; Cooper et al. 2013; Ross et al. 2014; Tiew and Drury 2012). Christensen and Turner (2008) propose the need to establish education programs, emphasising that spiritual care content may improve nurses' competency to understand the concepts of spirituality and spiritual care in depth, which may assist nurses to promote spiritual well-being in meeting the patients' spiritual needs. Furthermore, education may enlighten nurses on the concept of spiritual care as part of holistic care within the nursing paradigm and encourage nurses to meet their patients' spiritual needs equally with other needs (Christensen and Turner 2008). In fact, nursing and midwifery staff asserts the need to conduct more research in order to establish appropriate spiritual content and teaching methods to nurture spirituality (Mitchell and Hall 2007).

A limitation of this study may be the sample size (208) which did not meet the calculated requirement (375). This may be related to the inadequacy of time and unavoidable circumstances of the religious period of observance which caused participants less access to social media particularly Facebook. However, the confidence interval would have increased only marginally if the sample had been closer to that calculated. The homogenous sample such as participants' age and education qualification level also may have skewed the research results. As participants self-selected, it would be difficult to ensure the sample was representative. Replication of the study with a wide range of ages and educational backgrounds would lend further credibility to the results.

## Conclusion

Spiritual care is important to meet the holistic care needs of patients. Enhancing patients' spiritual resources is believed to contribute to inner peace. In this study, registered nurse participants showed positive perceptions of spirituality and spiritual care. However, they were uncertain about providing spiritual care to persons not-affiliated to a particular religion. The study demonstrated that education influenced the perceptions of participants about the spiritual dimension of nursing practice. Despite this, most participants considered that they had received insufficient spiritual education and training for them to be competent in providing spiritual care. Participants' perceptions of spirituality had a significant relationship with their perceptions of spiritual care. Therefore, it is imperative to educate nurses about the importance of spirituality in caring for patients holistically. Comprehensive educational programmes that adequately inform nurses about the spiritual dimension of nursing care are necessary in order to enable them to provide spiritual care that is competent and culturally appropriate.

**Compliance with Ethical Standards**

**Conflict of interest** No conflicts of interest to disclose.

**Ethical Standards** The study was approved by the Monash University Human Research Ethics Committee (MUHREC) under the category of low-risk studies (Project Number: CF15/857-2015000383). Participation in this online survey was fully voluntary and anonymous with no explicit incentives provided for participation. Implied consent was applied for this study, in which the submission of the online survey indicated the participant's consent to take part in the study. Participants were allowed not to answer any part of the survey without penalty. However, it was not possible to withdraw data, as the data provided by particular participants could not be identified once the online survey was submitted.

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