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Nurses' spiritual care competence for coronary heart disease patients

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ABSTRACT

Background: *Coronary Heart Disease (CHD) significantly impacts patients' physical, psychological, social, and spiritual well-being. Spiritual care has been shown to enhance coping, reduce emotional distress, and improve holistic health outcomes. However, spiritual care is often delegated to clergy, while nurses primarily focus on managing physical symptoms, resulting in unmet spiritual needs among patients with CHD.*
Objectives: *This study describes the spiritual care competence of Intensive Care Unit (ICU) nurses and identifies factors influencing this competence among nurses caring for CHD patients in hospitals across Tasikmalaya City.*
Methods: *This quantitative correlational study involved a total population of 95 ICU nurses from seven hospitals in Tasikmalaya City. Data were collected using the Spiritual Competency Scale (SCS). Multivariable associations were examined using ordinal logistic regression.*
Results: *Multivariate ordinal logistic regression identified three significant predictors of nurses' spiritual care competence. Nurses with ≤3 years of work experience were less likely to achieve higher competence than those with longer experience (OR = 0.26, 95% CI: 0.08–0.84, p = 0.024). Similarly, nurses who had never attended spiritual care training (OR = 0.20, 95% CI: 0.04–0.96, p = 0.044) and team leaders (OR = 0.16, 95% CI: 0.03–0.82, p = 0.028) showed significantly lower competence.*
Conclusions: *Work experience, previous spiritual care training, and nursing position were significant predictors of nurses' spiritual care competence. Nurses with limited experience, no prior training, and team-leader roles require greater support to strengthen their competence. Healthcare institutions should implement structured spiritual care education, continuous professional development, and mentorship programs.*

KEYWORD*: competence of nurses; coronary heart disease; intensive care unit; spiritual care; spiritual care competency*

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INTRODUCTION

Cardiovascular disease is the number one cause of death in the world. It is estimated 19.8 million people died from CVDs in 2022, representing approximately 32% of all global deaths. One of the cardiovascular diseases is Coronary Heart Disease (CHD) (1). CHD is the most common type of heart disease. This disease often occurs in adults less than 70 years old (2). In Indonesia, the number of CHD cases is quite high, especially in West Java (3). According to the results of the preliminary study, heart disease is included in the highest disease in the referral hospital in Tasikmalaya City (4).

A major cause of CHD is atherosclerosis (in which the walls of arterial blood vessels are attached to fatty deposits in the form of plaque)(5). The plaque can narrow the lumen of blood vessels so that it interferes with the distribution of oxygen and nutrients to the heart muscle (6). As a result, the heart muscle experiences ischemia (7).

Risk factors for atherosclerosis include lifestyle factors such as smoking, alcohol consumption, hypercholesterolemia, hypertension and Diabetes Mellitus (5). Meanwhile, other risk factors are lack of activity, excess body weight and a family history of heart disease (8). Age is also associated with the incidence of atherosclerosis (9). The main signs and symptoms of CHD are chest pain or angina pectoris, shortness of breath, pain all over the body, dizziness and nausea –(5). However, some people may not show symptoms until complaints of chest pain and even cardiac arrest appear (6). Persistent CHD can lead to myocardial dysfunction and increase the risk of heart failure (8).

CHD causes not only physical problems but also psychological problems. Psychological problems that often arise in patients with CHD are stress, anxiety and depression (10). Even these psychological problems can be interrelated with physical problems (10) . If a person experiences psychological problems such as depression, it can have an impact on the recurrence of CHD disease (10). These findings indicate that psychological well-being should be considered alongside physical health in patients with CHD. One of the strategies that can reduce anxiety and depression in CHD patients is spiritual care. This is in accordance with research that spiritual care can reduce anxiety and stress (11). By providing spiritual care, a person can achieve spiritual well-being (12). This is in accordance with research (12) that good health or spiritual well-being can keep CHD patients away from psychological problems such as depression.

A person who has spiritual well-being shows adaptation or adjustment to the condition of his disease, especially heart disease. This is in accordance with the results of the research that spiritual health is related to adjustment to illness in patients

with heart disease (13). In addition, spiritual care can also improve their quality of life. This is in accordance with research (14) that interventions related to religiosity or spiritual care can improve the quality of life of a person with cardiovascular disease.

Nurses as an integral part of health services have a role in providing spiritual care to patients while in the hospital. This is in accordance with the Health Sciences Consortium in 1989 which states that one of the roles of nurses is as a nursing caregiver. This nursing care is not only limited to the physical aspect of the patient but also to the spiritual aspect of the patient (15).

However, the implementation of spiritual care is still lacking. The results of observations in the field show that spiritual care is still provided by clergy. Nurses focus only on physical care and only study religion as part of the patient's demographic data, without a more detailed assessment of the patient's spiritual needs (16). This is in accordance with the results of the research (17) that the fulfillment of spiritual care in patients is still in the medium category.

This condition can occur due to several obstacles in the implementation of spiritual care, including: difficulty in examining patients' spirituality, ambiguity due to religious differences, lack of knowledge and competence of nurses, and lack of facilities (18). Therefore, it is very important to research on how nurses' competency in providing spiritual care to patients considering that Tasikmalaya is a city nicknamed the "City of Santri" (19). According to research, a good spiritual environment will support nurses in providing spiritual care (18,20). In addition, there are several factors that can influence nurses' competency in providing spiritual care to patients, including: age, level of education, previous spiritual care training, length of service, position and marital status (18).

Although many studies have examined spiritual care, evidence regarding factors associated with nurses' spiritual care competence in ICUs in Indonesia, particularly in Tasikmalaya, remains limited. By identifying factors associated with nurses' competence in providing spiritual care to patients with CHD, it is expected to improve the spiritual care competency of nurses so that it can reduce the incidence of anxiety and depression in CHD patients. By reducing anxiety and depression, this may contribute to better quality of life and potentially reduce adverse cardiovascular outcomes. Based on the description above, the main problem can be formulated: What are the factors associated with nurses' competency in providing spiritual care for CHD patients in the ICUs Tasikmalaya City Indonesia?

MATERIALS AND METHODS

This study was a quantitative correlation study that examines the factors associated with nurses' competency in providing spiritual care for CHD patients, namely: age, education, previous spiritual

care training, length of work, position and marital status. The Population in this study is ICU Room nurses in Tasikmalaya City which amounted to: 95 respondents. The sampling method in this study is total sampling. So that the number of respondents is equal to the number of the research population. The place where this research will be carried out in 7 General Hospitals in Tasikmalaya.

The study variables were "spiritual care competence" and the factors that influence it, namely: "age", "education", "previous spiritual care training", "length of service", "position" and "marital status". In terms of data collection, the researcher used an instrument to assess nurses' competency in providing spiritual care, namely the Spiritual Competency Scale (SCS) (26). This instrument consisted of 27 statements with several themes: 1) assessment and implementation of spiritual care as many as 6 statements 2) professionalism and improving the quality of spiritual care as many as 6 statements 3) personal support and counseling of patients as many as 6 statements 4) references as many as 3 statements 5) attitude towards the spirituality of the patient 4 statements and 5) communication as many as 2 statements. This instrument has been tested for validity and reliability and has been used in previous research in Indonesia. Cronbach's alpha scores ranged from 0.56 to 0.82. Validity was tested using Pearson's product-moment test with a significance level of 0.05 (21). Data were collected directly by the researcher from February to April 2025 using Google Forms. Before data collection, the researcher explained the study purpose, objectives, and procedures to all participants. Nurses who agreed to participate provided informed consent and completed the questionnaire.

The data analysis in this study used the multivariate ordinal logistic regression analysis test because the data in this study is multivariate and categorical data. This research pays great attention to research ethics, where the researcher applies the principles of (18): respect for person where the researcher respects the respondent's decision regarding his or her willingness or unwillingness to participate in the study and there is no coercion in the study, beneficence and nonmaleficence where the researcher conducts research without giving the slightest loss to the research respondents and the principles justice where the researcher treats all respondents the same without discriminating between the respondents' age, position, and background. The present study was approved by the Ethical Commission of the Faculty of Health, Universitas Bakti Tunas Husada Tasikmalaya Number: 061-01/E.01/KEPK-BTH/II/2025.

RESULTS AND DISCUSSION

The following section presents the empirical findings regarding the demographic and professional profiles of

the study participants. **Table 1** provides a comprehensive overview of respondent characteristics, including age, education, and professional experience across seven

Table 1. Characteristics of respondents based on hospital origin, age, last education, length of work, job title, previous spiritual care training, marital status and spiritual

Characteristics	n (%)
Hospital Origin	
General Hospital Hj Siti Muniroh	7 (7%)
General Hospital Permata Bunda Tasikmalaya	10 (11%)
General Hospital Prasetya Bunda	5 (5%)
Regional General Hospital Dr Soekardjo	19 (20%)
General Hospital Jasa Kartini	19 (20%)
General Hospital Tasik Medika Citratama	10 (11%)
General Hospital JHC Tasikmalaya	25 (26%)
Age Category	
Late Teens (17-25 years old)	22 (23%)
Early Adulthood (26-35 years old)	47 (49%)
Late Adulthood (36-45 years old)	22 (23%)
Early Elderly (46-55 years old)	4 (4%)
Late Elderly (56-65 years old)	0 (0%)
Education Category	
Diploma 3 Nursing	44 (46.3%)
Bachelor of Nursing	6 (6.3%)
Nursing Profession	45 (47.4%)
Length of Work Category	
New (≤3 tahun)	41 (43.2%)
Old (>3 tahun)	54 (56.8%)
Position Category	
Head of Room	3 (3%)
Team Leader	6 (6%)
Nurse	86 (91%)
Previous Spiritual Care Training Category	
Ever	9 (9.5%)
Never	86 (90.5%)
Marital Status Category	
Unmarried	30 (31.6%)
Marry	64 (67.4%)
Have been married	1 (1.1%)
Spiritual Care Competency	
Incompetent	5 (5.3%)
Low Competence	21 (22.1%)
Medium Competence	28 (29.5%)
High Competence	41 (43.2%)

hospitals in Tasikmalaya City.These data points establish the foundational context necessary for understanding the distribution of spiritual care competency among the surveyed ICU nurses.

Based on **Table 1**, it appears that most of the respondents came from JHC Tasikmalaya Hospital as many as 25 people (26%). Based on age, most of them are in the Early Adult age category (26-35 years) as many as 47 people (49%). Based on the last education, most of the last education of nurses is the nurse profession as many as 45 people (47.4%). Based on the length of work, most of them are in the category of working more than 3 years as many as 54 people (56.8%). Based on position, most of them play the role of implementing nurses as many as 86 people (91%). Based on the previous spiritual care training, most of them had never participated in spiritual care training as many as 86 people (90.5%). Based on marital status, most of them are married as many as 64 people (67.4%). It appears that most of nurses' competency in providing spiritual care is in the high competence category of 41 people (43.2%), and a small part is in the incompetent category of 5 people (5.35%).

Based on **Table 1**, most nurses' spiritual care competence in providing spiritual care is in the high competence category and a small part is in the incompetent category. This finding should be interpreted in the context of the respondents' professional and sociocultural characteristics.

In accordance with the statement that Tasikmalaya is a city of students who are known as a religious city (22). This is supported by the results of the research that religion is very closely related to the spiritual care competence of a nurse (23). With nurses' high spiritual care competencies, this can certainly have a positive effect on patients, as nurses can fulfill their spiritual needs. Based on Florence Nightingale's holistic perspective, nurses not only fulfil the physical and mental needs of patients but also their spiritual needs (23).

The results of this study are in accordance with the results of the studies that most of the competency of nurses in providing spiritual care is in the category of high competence (23,24). However, other studies have reported lower levels of spiritual care competence among nurses (23). This is because there are obstacles, namely: lack of knowledge about spiritual care, high workload and lack of nurses' confidence in carrying out spiritual care.

Table 2. Results of multivariate ordinal logistic regression analysis of factors related to nurses' spiritual care competence in the ICU of Hospitals in Tasikmalaya City

Variable	β	SE	Wald	P value	OR (95% CI)
Length of Service (≤3 Years)	-1.332	0.589	5.110	0.024	0.26 (0.08–0.84)
Team Leader	-1.815	0.827	4.814	0.028	0.16 (0.03–0.82)
Head Nurse	0.446	1.329	0.112	0.738	1.56 (0.12–21.14)
Diploma in Nursing	-1.871	1.087	2.966	0.085	0.15 (0.02–1.29)
Professional Nursing Degree	-0.972	1.084	0.805	0.370	0.38 (0.05–3.16)
No Training	-1.616	0.804	4.046	0.044	0.20 (0.04–0.96)

Table 2 presents the results of the multivariable ordinal logistic regression analysis of factors associated with nurses' spiritual care competence. Three variables were identified as significant predictors. Nurses with ≤3 years of work experience were less likely to have higher spiritual care competence than those with more than three years of experience (β = −1.332, OR = 0.26, 95% CI: 0.08–0.84, p = 0.024). Similarly, nurses who had never attended spiritual care training had significantly lower odds of achieving higher competence than those who had received training (β = −1.616, OR = 0.20, 95% CI: 0.04–0.96, p = 0.044). In addition, team leaders showed lower odds of higher competence compared with staff nurses (β = −1.815, OR = 0.16, 95% CI: 0.03–0.82, p = 0.028). In contrast, head nurse position and educational level were not significantly associated with spiritual care competence (p > 0.05).

Based on the results of the research presented in **Table 2**, it appears that there are several factors that associated with nurses' competency in providing spiritual care to patients with CHD in the ICU of Hospitals throughout Tasikmalaya City: Work experience, previous spiritual care training, and professional position. The present study found that Odds Ratio (OR) = 0.26 (95% CI: 0.08–0.84) means that nurses with ≤3 years of service have a 0.26 times greater chance of achieving a higher level of spiritual care competency compared to nurses with >3 years of service, after controlling for other variables in the model. In other words, newly employed nurses have approximately 74% lower odds of having a higher level of spiritual care competency compared to more experienced nurses.

Based on the data above shows that nurses with more than three years of work experience were more likely to demonstrate higher spiritual care competence than those with shorter work experience. This finding is consistent with previous studies reporting that clinical experience is an important determinant of spiritual care competence (25). Longer work experience provides nurses with greater exposure to diverse patient needs, enabling them to develop stronger assessment, communication, and intervention skills related to spiritual care. In addition, experienced nurses generally have

higher self-confidence, greater opportunities to participate in continuing professional development, and more frequent exposure to complex clinical situations requiring spiritual support (17,25). These cumulative experiences contribute to the development of practical competence that extends beyond knowledge gained through formal education. Another factor that associated with nurse's spiritual care competence is previous spiritual care training. The study found that Nurses who had never attended spiritual care training were significantly less likely to achieve higher levels of spiritual care competence than those who had received training (β = −1.616, SE = 0.804, Wald = 4.046, OR = 0.20, 95% CI: 0.04–0.96, p = 0.044). This finding indicates that the absence of previous spiritual care training was associated with substantially lower odds of demonstrating higher spiritual care competence after adjustment for other variables.

From the result of the study revealed that nurses who had never attended spiritual care training were significantly less likely to demonstrate higher spiritual care competence than those who had received training. This finding is consistent with previous studies identifying training as one of the strongest determinants of nurses' spiritual care competence (25,27). Spiritual care training enhances nurses' knowledge, practical skills, and confidence in assessing and addressing patients' spiritual needs. It also improves communication skills and promotes positive attitudes toward integrating spirituality into holistic nursing care (28,29). Furthermore, training provides opportunities for continuing professional development and evidence-based practice, enabling nurses to deliver more comprehensive and patient-centered spiritual care (29).

Another factor related to nurse competence is position. The study showed that team leaders were significantly less likely to achieve higher levels of spiritual care competence than staff nurses (β = −1.815, SE = 0.827, Wald = 4.814, OR = 0.16, 95% CI: 0.03–0.82, *p* = 0.028). This finding indicates that nurses serving as team leaders had significantly lower odds of demonstrating higher spiritual care competence than staff nurses after adjustment for other variables.

The study found that team leaders were less likely to demonstrate higher spiritual care competence than staff nurses. This finding may reflect the additional coordination, supervision, and administrative responsibilities of team leaders. Although previous studies have rarely identified professional position as an independent determinant of spiritual care competence, this finding may be explained by differences in clinical roles and responsibilities. Team leaders generally undertake additional coordination, supervision, and administrative tasks, which may reduce opportunities for direct patient interaction and the provision of spiritual care

(28). In contrast, staff nurses spend more time providing bedside care, enabling them to assess and address patients' spiritual needs more frequently. Furthermore, professional position is often associated with accumulated clinical experience and leadership responsibilities (15).

Nevertheless, this finding should be interpreted cautiously because the number of team leaders included in the study was relatively small, which may have affected the stability of the regression estimates. In the bivariate analysis, age, education, and length of service were significantly associated with spiritual care competence, whereas position, previous spiritual care training, and marital status were not. In the multivariable model, however, only length of service, previous spiritual care training, and team-leader position remained significant predictors.

In the present study, nurses' age was not considered an independent determinant of spiritual care competence. This finding is consistent with previous evidence suggesting that chronological age alone does not necessarily improve nurses' ability to provide spiritual care. Instead, competence is developed through clinical experience, continuing education, and participation in spiritual care training (27,28). Spiritual care competence reflects a combination of knowledge, communication skills, attitudes, and practical experience rather than biological age. Furthermore, studies have shown that factors such as spiritual care education, professional experience, self-efficacy, and perceptions of spirituality are more influential predictors of competence than demographic characteristics (28,29). Therefore, opportunities for continuous professional development may have a greater impact on spiritual care competence than age itself.

The present study found that educational level was not independently associated with nurses' spiritual care competence after adjustment for other variables. This finding suggests that formal academic qualifications alone may not be sufficient to develop competence in providing spiritual care. Previous studies have indicated that spiritual care competence is primarily acquired through clinical experience, continuing professional development, and specific spiritual care training rather than educational attainment alone (17,27).

Although nursing curricula introduce the concept of holistic care, opportunities to practice spiritual care during formal education are often limited. Consequently, nurses with different educational backgrounds may demonstrate comparable levels of competence when they receive similar clinical exposure and professional training. Furthermore, the relatively homogeneous educational distribution in this study may have reduced the ability to detect significant differences between educational groups. Marital status is one

factor that cannot influence the nurses' spiritual care competency. The results of this study are in line with research that marital status does not influence nurses' competency in providing spiritual care (27). However, it is different from the results of previous study that nurses' spiritual care competency is actually higher in married nurses than in unmarried nurses (26).

The findings highlight the need to integrate structured spiritual care training into continuing nursing education, particularly for early-career nurses and those working in intensive care units. Hospitals should establish mentorship programs, provide regular competency-based training, and incorporate spiritual care into clinical supervision to strengthen nurses' confidence and practical skills. Nursing managers should also foster a supportive practice environment that enables nurses to routinely assess and address patients' spiritual needs. These strategies may enhance the quality of holistic nursing care and improve patient-centered outcomes among patients with coronary heart disease in the ICU.

CONCLUSION AND RECOMMENDATION

Work experience, spiritual care training, and nursing position significantly influence nurses' spiritual care competence. Nurses with limited experience, no prior training, and team leader roles require greater support to strengthen their competence. Healthcare institutions should implement structured spiritual care education, continuous professional development, and mentorship programs, particularly for less experienced nurses and nursing leaders, to enhance holistic care quality and improve patient-centered outcomes in coronary heart disease care.

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