International Journal of Research Studies in Management
2025 Volume 13 Number 6, 77-91

Ecumenical spiritual practices among nurses: Towards strengthening the integration of spiritual care in hospital setting

Aliling, Lealyn S.
University of La Salette, Inc., Philippines (alilinglealyn@gmail.com)

ISSN: 2243-7770
Online ISSN: 2243-7789

Received: 8 June 2025 **Revised**: 10 July 2025 **Accepted**: 15 July 2025 OPEN ACCESS
Available Online: 18 July 2025 **DOI**: 10.5861/ijrsm.2025.25081

Abstract

This study explored ecumenical spiritual practices among nurses as a foundation for strengthening the integration of spiritual care in the hospital setting. This study utilized a descriptive-correlational research design and conducted in the three selected hospitals in Isabela. An adopted survey questionnaire was administered to 55 nurses. Frequency, percentage, mean and chi-square test were used to statistically analyze the gathered data. The findings of this study indicate that nurses consistently practice and value the importance of spiritual care across multiple dimensions. This infers a strong commitment among nurses to integrate spiritual care into their practice, highlighting its significance in holistic healthcare. In addition, the findings suggest that ecumenical spiritual practices among nurses are not significantly influenced by demographic variables such as sex, age, educational attainment, religion, and workload. This implies that the practice of ecumenical spirituality transcends individual demographic differences vi and may instead be shaped by external factors such as institutional culture, workplace policies, availability of spiritual care resources, professional training, and other factors. The findings underscore the need for standardized tools, focused training programs, and institutional policies to enhance nurses' ability to recognize and address patients' spiritual needs comprehensively and consistently. Additionally, healthcare facilities should prioritize creating accessible spaces for spiritual care, institutionalizing supportive practices, and providing resources to cater to diverse spiritual requirements.

Keywords: ecumenical, spiritual practices, holistic nursing care

Ecumenical spiritual practices among nurses: Towards strengthening the integration of spiritual care in hospital setting

1. Introduction

A person's self-perception shapes his life greatly in terms of not just physical and psychological but also spiritual well-being. Holistic health acknowledges that, especially in cases of medical conditions, coping mechanisms and general health depend on spiritual demands which are natural. Patients who have physical issues can struggle with concerns of meaning, faith, and purpose, so spiritual and religious considerations are very important to their healing process. Lack of spiritual well-being can cause a reduced hope and negatively impact quality of life. In recent years, there has been a growing emphasis on holistic patient care, with organizations like the World Health Organization (WHO) promoting a model that integrates physical, mental, social, and spiritual dimensions of health. Recent studies have reinforced the significance of spiritual care in improving patient outcomes, particularly in palliative and critical care settings (Balboni et al.,2022). However, despite this recognition, integrating spiritual care into nursing practice remains a challenge. Research highlights that while healthcare professionals acknowledge the importance of spiritual well-being, they often face barriers such as lack of training, time constraints, and ambiguity in addressing patients' spiritual needs (Ramezani et al.,2021).

This research paper aims to explore the ecumenical spiritual practices among nurses. It focuses on how nurses can incorporate spiritual practices—such as prayer, meditation, and spiritual counseling—into care plans to enhance patient-centered care and improve health outcomes. By elucidating how a balanced nursing plan that includes spiritual interventions can contribute to patient well-being, this paper aims to provide a framework for integrating spiritual care into holistic nursing practices. The findings are intended to offer a foundation for future research, helping to better equip nursing professionals to address the diverse spiritual needs of their patients and enhance the overall effectiveness of patient care.

Objectives of the Study - This study aimed to determine the ecumenical spiritual practices of nurses in providing care among patients in selected hospitals in Isabela. Specifically, it sought to: (1) identify the profile of the respondents in terms of sex, age, educational attainment, school graduated, religion, and workload every shift; (2) determine the ecumenical spiritual practices of nurses in providing care in terms of general and specific manifestations in rendering spiritual care, recipients of spiritual care, venue and appropriate time for rendering spiritual care, relevance or meaning of spiritual care, and institutional support; and (3) assess whether there is a significant relationship between the nurses' ecumenical spiritual practices and their profile variables.

2. Methods

Research Design - The researcher employed a descriptive-correlational design to evaluate the ecumenical spiritual practices among nurses working in three selected hospitals in Isabela and establish its relationship to their profile variables. This research does not determine causation but offers insights into the strength and direction of relationships among variables. A descriptive-correlational design was suitable for the study as it sought to investigate and delineate the ecumenical spiritual practices among nurses, focusing on their characteristics and variances across several hospital environments. Furthermore, the researcher recorded these acts methodically within their context. This strategy enabled the researcher to examine the correlation between nurses' spiritual activities and their demographic factors. This strategy proved appropriate for discovering and quantifying the strength and direction of correlations without variable manipulation.

Study Site and Participants - This study was conducted in the province of Isabela, focusing on nurses employed in three selected hospitals, including both private and government institutions. The participants

consisted of nurses currently working at these hospitals. The objective was to assess the ecumenical spiritual practices of nurses in delivering holistic nursing care. This examination helped determine how well these spiritual practices were incorporated into the overall approach to patient care in the selected healthcare settings.

Population, Sample Size, and Sampling Method - The population of the study consisted of 55 nurses in three selected hospitals in Isabela (Hospital A=25, Hospital B=15, and Hospital C=15). A total enumeration sampling method was used to include all nurses currently employed at these hospitals. Total enumeration guarantees data collection from every individual or unit within the population, yielding a comprehensive dataset. This methodology is especially vital when the population is limited, or everyone's viewpoint is essential to the study's aim.

Research Instrument - The researcher used a survey questionnaire for data collection. The questionnaire was adopted from the study titled "Integration of Ecumenical Care Practices in Providing Holistic Care for Patient." This was consisted of 58 structured subscale items, all framed in a declarative format and grouped into seven domains related to the ecumenical spiritual practices in nursing care: 1. General Manifestation in Rendering Spiritual Care (4 items); 2. Specific Manifestation in Rendering Spiritual Care (14 items); 3. Recipients of Spiritual Care (10 items); 4. Venue for Rendering Spiritual Care (4 items); 5. Appropriate Timing for Rendering Spiritual Care (6 items); 6. Relevance and Meaning of Spiritual Care (10 items); and 7. Institutional Support (10 items). The questionnaire employed a four-point Likert scale for responses: 4: Strongly Agree – indicated that the nurse consistently practiced spiritual care as outlined in the tool; 3: Agree – reflected that the nurse frequently practiced spiritual care in alignment with the tool's guidelines; 2: Disagree – showed that the nurse rarely practiced spiritual care as described; and 1: Strongly Disagree – suggested that the nurse did not practice spiritual care or did so infrequently.

Data Gathering Procedure - The researcher followed a systematic approach to conduct the study. Permission to conduct the research was first secured from the selected hospitals in Isabela, specifically through the office of each hospital administrator. Once approval was obtained, the researcher prepared the primary data-gathering tool—a questionnaire. This adopted instrument was reproduced according to the total number of respondents, with informed consent forms attached to each copy. The questionnaires were then distributed to the identified respondents, who were nurses working in the three selected hospitals. Distribution was done face-to-face to allow for questions and clarifications, and to encourage full participation. The purpose of the study was clearly explained, and respondents were asked to sign the informed consent forms. Given the number of items in the questionnaire, nurses were allowed up to one week to complete it. The researcher conducted regular follow-ups and reminders to ensure timely completion. Clear instructions were provided on the deadline for submission, and additional reminders were issued to promote prompt return of the questionnaires.The completed questionnaires were kept secure to maintain confidentiality and ensure that only authorized personnel had access to the data. Finally, the collected responses were carefully tabulated and analyzed. Appropriate statistical tools were used with the assistance of a qualified statistician to interpret the data and derive meaningful conclusions.

Data Analysis - The following statistical measures were employed in the study to analyze the gathered data. Frequencies and percentages were used to determine the profile of the respondents, specifically in terms of sex, age, educational attainment, school graduated, religion, and workload per shift. To assess the nurses' ecumenical spiritual practices, the mean was utilized, covering aspects such as general and specific manifestations in rendering spiritual care, recipients of spiritual care, venue and appropriate timing for rendering spiritual care, the relevance or meaning of spiritual care, and the institutional support available. A 4-point Likert scale served as the basis for analyzing and interpreting these responses. Additionally, the Chi-Square Test was applied to identify any significant relationship between the nurses' spiritual care practices and their profile variables.

Ethical Considerations - The researcher ensured that respondents' identities were kept confidential and not disclosed to anyone outside the research team. This commitment to confidentiality encouraged participants to

share their thoughts and opinions more freely, knowing that their responses would be protected. Also, the researcher carefully weighed the potential benefits and risks associated with any necessary manipulation or deception. If deception was used, participants were fully debriefed at the end of the study, and any misleading elements were clarified. This ensured that respondents were informed about the study's true nature and purpose, and any questions or concerns they had were addressed. In addition, the researcher took full responsibility for safeguarding participants from any form of harm, including emotional distress, mental stress, embarrassment, or discomfort. The study was conducted in a way that ensured no negative impact on the participants' professional development, personal well-being, or mental health. There was an implementation of strict measures to protect data from unauthorized access, misuse, or inappropriate disclosure. Data were securely stored and handled to prevent tampering, improper deletion, or destruction. The results were presented and shared in a manner that respected the integrity and confidentiality of the information collected.

3. Results and discussion

Table 1
Distribution of the Respondents According to Their Demographic Profile

Sex	Frequency	Percentage
Male	13	23.6
Female	42	76.4
Age	Frequency	Percentage
20-25 years old	11	20.0
26-30 years old	7	12.7
31-35 years old	12	21.8
36-40 years old	12	21.8
41-45 years old	4	7.3
46-50 years old	3	5.5
51-55 years old	6	10.9
Educational Attainment	Frequency	Percentage
Bachelor's Degree	47	85.5
Masteral Units	4	7.3
Masteral Degree	4	7.3
School Graduated	Frequency	Percentage
Private Sectarian (Catholic/Christian)	34	61.8
Private Non-sectarian	14	25.5
Government (College/University)	7	12.7
Religion	Frequency	Percentage
Catholic	39	70.9
Born Again	6	10.9
Methodist	6	10.9
Baptist	2	3.6
Muslim	2	3.6
Workload Every Shift - Patients Each Shift	Frequency	Percentage
Approximately 5 to 10	20	36.4
Approximately 11 to 20	24	43.6
More than 20	11	20.0
Workload Every Shift - Time of Shift	Frequency	Percentage
8-10 hours	25	45.5
10-12 hours	22	40.0
More than 12 hours	8	14.5

As reflected in Table 1, regarding sex, the majority of respondents, 42 or 76.4%, identify as females, while males make up 13 or 23.6% of the total respondents. Regarding the age categories, respondents range from 20 to 55. Most of the respondents, 12 or 21.8%, are ages 31-35 and 36-40, respectively. The second most common age group is 20-25, representing 11 or 20% of respondents. On the other hand, the age group of 46-50 years old has the lowest frequency of 3 or 5.5%.

Additionally, 47 or 85.5% of respondents are bachelor's degree holders. This is followed by master's graduate and master's units, which constitute 4 or 7.3% of the total. Regarding the school graduated category, 34 or 61.8% graduated in private sectarian. This is followed by 14 or 25.5% of graduates from private non-sectarian

schools. Lastly, only 7 or 12.7% of graduates are government college/university graduates. In terms of their religion, the majority of the respondents are Catholic, which constitutes 39 or 70.9% of the respondents. Meanwhile, there is only 2 or 3.6% that constitutes Baptist and Muslim. Lastly, the table shows that 24 or 43.6% of the respondents have approximately 11 to 20 hours of workload every shift (number of patients per shift). 25 or 45.5% of respondents have 8-10 hours of shift.

Table 2
Ecumenical Spiritual Practices of Nurses in terms of General Manifestation in Rendering Spiritual Care

Items	Mean	Interpretation
1. During admission, I ask my patients' religion.	3.75	Practice/ concur with the opinion on spiritual care at all times.
2. I observe the presence of religious items in my patients, such as rosary beads and Buddha beads. Bible, etc.	3.31	
3. I utilize the Checklist/Assessment tool related to spiritual needs (if applicable).	3.22	
4. I render spiritual care as an expression of the hospital's mission and vision (if applicable).	3.51	
Category Mean	3.45	

As revealed in Table 2, they always practice the following about general manifestation in rendering spiritual care: asking about their patients' religion during admission (M=3.75), rendering spiritual care as an expression of hospital mission and vision (M=3.51), and observing the presence of patients' religious items (M=3.31). On the other hand, they often practice utilizing checklist/assessment tools related to spiritual needs. With a category mean of 3.45, this implies that the nurses always practice spiritual aspects in rendering care to the patients. This means that nurses regularly integrate spiritual elements into patient care, including noting the existence of religious objects, recognizing patients' religious affiliations, and coordinating their practices with the hospital's mission and vision. This illustrates their dedication to holistic care and attending to spiritual and physical requirements. By providing spiritual care in line with the hospital's mission and vision, nurses demonstrate that they align with the organization's objectives and reaffirm the significance of spirituality as a fundamental aspect of patient care.

As shown in Table 3, nurses always practice all the indicated items. Specifically, item 4, "I maintain an open mind and heart for individual's religious practices," got the highest mean of 3.73. This is followed by item 4, "I provide privacy by giving patients and relatives space for prayer," with a mean of 3.73. On the other hand, the following got the lowest scores: I am sincere about my patient's concern, e.g., requesting confession before the operation (M=3.38), and I document my spiritual care in the nurse's notes (M=3.36). Although rated low, they still practice these at all times. With a category mean of 3.55, this indicates that the nurses always practice specific manifestations in rendering spiritual care to the patients. This implies that nurses should first consider patients' different spiritual views and practices. This suggests that nurses should consider patients' diverse spiritual beliefs and behaviors. This suggests a patient-centered strategy intended to increase comfort and self-assurance in the therapeutic environment. The relatively lower ratings for sincerity in addressing spiritual issues (e.g., requests for confession) and recording spiritual care point to areas where nurses may improve their work even more. Although these are still regularly followed, more training or better policies may provide chances for development. The general good evaluations show that nurses regularly use spiritual care, promoting comprehensive patient treatment.

Table 3
Ecumenical Spiritual Practices of Nurses in terms of Specific Manifestation in Rendering Spiritual Care

Items	Mean	Interpretation
1. I respond promptly to requests on spiritual matters, e.g. Priests/pastors/counselors services (anointing, receiving communion, blessings).	3.47	Practice/ concur with the opinion on spiritual care at all times.
2. I offer silent prayers when at home, especially to those terminally ill.	3.49	
3. I utilize -therapeutic-communication" questions, e.g., "W/hat would you like to talk about?"; "What's bothering you?"	3.51	
4. I provide privacy by giving patients and relatives space for prayer.	3.73	
5. I respect dietary preferences based on one's faith, e.g . as a Muslim, Jehovah, or Adventist. (if Applicable)	3.71	
6. Part of spiritual care is empathizing with the patient.	3.65	
7. I maintain an open mind and heart for individual's religious practices.	3.76	

8. I listen attentively to my patient's stories.	3.56
9. I anticipate the need for spiritual intervention, e.g., anointing, communion, blessing, pray-over.	3.40
10. Spiritual care is part of the nurses' daily care.	3.53
11. I am sensitive to non-verbal cues, e.g., silence, facial grimaces.	3.62
12. I pray before any diagnostic and therapeutic procedure.	3.56
13. I am sincere about my patient's concern, e.g., requesting confession before the operation.	3.38
14. I document my spiritual care in the nurse's notes.	3.36
Category Mean	3.55

Dealing with the found areas for growth will help increase the quality and efficacy of spiritual care, guaranteeing that all facets of patients' spiritual needs are fully satisfied. As reflected in Table 4, nurses consistently agree with the view on spiritual care in all the listed statements. With a mean of 3.80, item 4, "A patient in the OR (Operating Room)/undergoing surgery needs spiritual attention," clearly got highest. Item 2, "The critically ill and dying most frequently need spiritual care," with a mean of 3.76 comes next. Patients in pain need spiritual attention (M=3.53), while patients who are psychologically unwell, e.g., depressed, suicidal, confused, need spiritual attention (M=3.36), earned the lowest scores. Though rated low, they constantly engage in these activities. With a category mean of 3.67, this indicates that nurses strongly associate spiritual care with critical or life-threatening situations. The result reflects their awareness of the heightened need for emotional and spiritual support during these vulnerable moments. Also, it suggests a potential gap in recognizing the importance of spiritual attention in non-critical situations. Although nurses often participate in these activities, the lower mean scores point to a chance to emphasize the need of spiritual care for mental and emotional health equally. The results also highlight the need of including spiritual care into every patient's regular treatment, not only those of acute or critical state. This can help ensure that patients with psychological or emotional challenges receive adequate spiritual support.

Table 4

Ecumenical Spiritual Practices of Nurses in terms of Recipients of Spiritual Care

Items	Mean	Interpretation
Patients who are psychologically ill, e.g., depressed, suicidal, confused, need spiritual attention.	3.36	Practice/ concur with the opinion on spiritual care at all times.
The critically ill and dying most frequently need spiritual care.	3.76	
Palliative care and hospice patients need spiritual care.	3.71	
A patient in the OR (Operating Room)/ undergoing surgery needs spiritual attention.	3.80	
Patients who received bad laboratory results, e.g., cancer, need spiritual care.	3.71	
Patients in pain need spiritual attention.	3.53	
All patients, including well patients, need spiritual care.	3.71	
Patients who are losing hope, e.g., HIV victims and cancer patients, need spiritual care.	3.75	
Happy and grateful patients, e.g., patients for discharge, need spiritual care.	3.73	
Abused patients, e.g., battered wife/child, need spiritual attention.	3.67	
Category Mean	3.67	

Table 5

Ecumenical Spiritual Practices of Nurses in terms of Venue for Rendering Spiritual Care

Items	Mean	Interpretation
Spiritual care can be given anywhere if there is privacy.	3.64	Practice/ concur with the opinion on spiritual care at all times.
A silent and peaceful environment for meditation and prayer is a place for spiritual care.	3.73	
Spiritual care can be rendered in a patient's room	3.65	
Spiritual care is preferably done in the chapel/prayer room of the institution.	3.47	
Category Mean	3.62	

Table 5 illustrates that nurses consistently agree with the view on spiritual care in all the listed statements. As reflected, item 2, "A silent and peaceful environment for meditation and prayer is a place for spiritual care," clearly got highest. Item 3, " Spiritual care can be rendered in a patient's room," with a mean of 3.65 comes next. Moreover, item 1 “Spiritual care can be given anywhere if there is privacy,” got a mean score of 3.62. On the other hand, item 4 “Spiritual care is preferably done in the chapel/prayer room of the institution” with a mean of

3.47 got the lowest.

With a category mean of 3.62, this emphasizes the need to set aside specific areas for spiritual healing in medical establishments. Such surroundings can improve the nature of spiritual contacts and give patients and relatives comfort and connection. The high ratings for spiritual care in a patient's room or any other private setting demonstrate how adaptable nurses are in meeting patients' spiritual needs regardless of their environment. This flexibility is necessary to ensure that all patients receive spiritual care, even those unable to travel to designated venues like chapels or prayer rooms. The comparatively low rating for spiritual care in prayer rooms or chapels suggests that these locations may not be as necessary for offering spiritual care as other locations. This may indicate a preference for faster, patient-focused environments, practical challenges, or ignorance. The findings further emphasize how vital solitude and peaceful environments are for providing effective spiritual care. Fostering deep spiritual connections depends on these parameters being met in patient rooms or other venues.

Table 6
Ecumenical Spiritual Practices of Nurses in terms of Appropriate Time in Rendering Spiritual

Items	Mean	Interpretation
1. Spiritual care is rendered when the patients request for it, e.g., to receive anointing.	3.47	Practice/ concur with the opinion on spiritual care at all times.
2. Spiritual care is appropriately done when the patient is calm and willing to listen.	3.73	
3. Spiritual care is given to patients in their lowest moments.	3.75	
4. Spiritual care is given every time nurses interact with the patients.	3.55	
5. Spiritual care is given when an emergency procedure is to be done with unknown outcomes.	3.69	
6. Spiritual care is given in the morning as a daily routine.	3.60	
Category Mean	3.63	

Table 6 shows that nurses consistently agree with the view on spiritual care on the following: Spiritual care is given to patients in their lowest moments (M=3.75); Spiritual care is appropriately done when the patient is calm and willing to listen (M=3.73); Spiritual care is given when an emergency procedure is to be done with unknown outcomes (M=3.69); Spiritual care is given in the morning as a daily routine (M=3.60); Spiritual care is given every time nurses interact with the patients (M=3.55); and Spiritual care is rendered when the patients request for it, e.g., to receive anointing (M=3.47).

The overall mean of 3.63 indicates that nurses are highly conscious of the significance of attending to patients' spiritual needs when they are most vulnerable. This emphasizes that spiritual care is essential or that psychological and emotional support is offered in trying or upsetting times. The significance of timing and patient receptiveness is highlighted by the high mean score for spiritual care when the patient is at ease and open to listening. This implies that nurses understand the importance of providing spiritual care. The emphasis on spiritual care during emergency treatments with unknown outcomes shows its function in giving consolation and confidence in stressful, life-altering situations. When it is most significant and effective for the patient, this aligns with the holistic approach to nursing care, which addresses physical and emotional well-being. A dedication to incorporating spirituality into the typical nursing work-flow is shown by offering spiritual care as part of a daily routine and throughout every patient encounter. This regular integration guarantees that spiritual care is always accessible and not situation-specific.

As reflected in Table 7, item 7, "Spiritual care is respecting patients as human beings with heartedness," clearly got the highest mean of 3.80. It is followed by item 3, "Spiritual care allows patients to practice their faith/beliefs," with a mean of 3.76. Moreover, item 5, "Spiritual care prepares patients to accept their illness/condition," got a mean score of 3.75. On the other hand, items 2 and 9, "Spiritual care is done through counseling and using therapeutic communication," and "Integrating spirituality, like saying prayers, is a daily routine of healing in nursing," with a mean of 3.69, the lowest.

Table 7
Ecumenical Spiritual Practices of Nurses as to Relevance/Meaning of Spiritual Care

Items	Mean	Interpretation
1. Spiritual care is based on the patient's religion. Beliefs and faith.	3.71	Practice/ concur with the opinion on spiritual care at all times.
2. Spiritual care is done through counseling and using therapeutic communication.	3.69	
3. Spiritual care allows patients to practice their faith/beliefs.	3.76	
4. Spiritual care is a priority aspect of holistic nursing care.	3.71	
5. Spiritual care prepares patients to accept their illness/condition.	3.75	
6. Spiritual care is compassion.	3.73	
7. Spiritual care is respecting patients as human beings with heartedness.	3.80	
8. Spiritual care is assured when patients have a positive attitude towards their illness.	3.71	
9. Integrating spirituality, like saying prayers, is a daily routine of healing in nursing	3.69	
10. Taking care of patients with empathy is spiritual care.	3.73	
Category Mean	3.73	

With a category mean of 3.73, this indicates that compassion and empathy play a crucial part in spiritual care. This emphasizes how vital it is to treat patients respectfully and acknowledge their inherent worth, as this promotes comfort and trust in the nurse-patient interaction. The significant degree of agreement with the claim that spiritual care helps patients exercise their faith and beliefs shows the nurses' dedication to providing a friendly environment for various spiritual manifestations. This is consistent with holistic treatment, which addresses the spiritual component of health and physical and psychological needs. The high mean score for the role of spiritual care in patients' acceptance of their illness or condition underlines its relevance for promoting psychological health and emotional resilience. This suggests that spiritual care is necessary for helping patients to overcome the challenges of their medical route. Given the comparatively low scores for therapeutic communication and spiritual care through therapy, there may be room for improvement. Nurses can be better equipped to have meaningful conversations with patients about their spiritual needs and concerns if they receive training and education.

It can be gleaned from table 8 that item 1, "The availability of the chapel/prayer room as a place of worship is necessary for spiritual care," got the highest mean of 3.67. It is followed by item 2, "Provision of institutional assessment tools is integrated in spiritual care," with a mean of 3.53. Moreover, item 3, "Daily blessing of patients from religious sisters/priests is a spiritual care component," got a mean score of 3.49. On the other hand, items 4 and 8, " A built-in speaker placed in each room for accessibility to hearing daily mass is essential for spiritual care," and " The provision of religious leaflets to patients augments spiritual care," with mean scores of 3.31 and 3.36, respectively.

Table 8
Ecumenical Spiritual Practices of Nurses as to Institutional Support

Items	Mean	Interpretation
1. The availability of the chapel/prayer room as a place of worship is necessary for spiritual care.	3.67	Practice/ concur with the opinion on spiritual care at all times.
2. Provision of institutional assessment tools is integrated in spiritual care.	3.53	
3. Daily blessing of patients from religious sisters/priests is a spiritual care component.	3.49	
4. A built-in speaker placed in each room for accessibility to hearing daily mass is essential for spiritual care.	3.31	
5. Stipulation of Spiritual Care in FDAR (Focus Data Action Response) documentation is part of spiritual care.	3.44	
6. Spirituality imparted to all nursing staff through integration in culture and sensitivity seminar given by the HR is crucial in spiritual care.	3.47	
7. A checklist is utilized in assessing spiritual needs upon admission (if applicable)	3.42	
8. The provision of religious leaflets to patients augments spiritual care.	3.36	
9. Providing spiritual care through visitations and offering Christian songs helps patients. (if applicable)	3.42	
10. A chaplain is available to give needs such as anointing the sick, blessing, giving communion, etc.	3.45	
Category Mean	3.46	

A category mean of 3.73 signifies that compassion and empathy are essential components of spiritual care. This underscores the need of treating patients with respect and recognizing their intrinsic value, since this fosters comfort and trust in the nurse-patient relationship. The nurses' commitment to creating a welcoming space for different forms of spiritual expression is demonstrated by the high level of agreement with the claim that spiritual care assists patients in practicing their faith and beliefs. This aligns with the principles of holistic treatment, which take into account not only the physical and mental aspects of well-being but also the spiritual dimension. The significance of spiritual care in helping patients accept their disease or condition is shown by its high mean score, which indicates its value for developing emotional resilience and psychological wellness. This offers more proof that spiritual care is crucial for helping patients negotiate challenges they could encounter on their path of treatment. Therapeutic communication and spiritual care through treatment have somewhat low ratings, hence there could be opportunity for development. Nurses can be better equipped to have meaningful conversations with patients about their spiritual needs and concerns if they receive training and education.

Table 10
Chi-Square Test of Independence between the Nurse's Ecumenical Spiritual Care Practices and their Profile Variables

Level of Nurses Integration on Ecumenical Spiritual Care	x^2	df	p-value
Sex	0.933	2	0.627
Age	3.573	12	0.329
Educational attainment	1.593	4	0.810
School Graduated	3.039	4	0.551
Religion	7.914	8	0.442
Workload Every Shift - Patients Each Shift	0.676	4	0.954
Workload Every Shift - Time of Shift	1.638	4	0.802

The Chi-Square test results indicate that there is no statistically significant relationship between the ecumenical spiritual care practices of nurses and their profile variables. The test results showed no significant relationship between the two variables, as all p-values are greater than the 0.05 significance level. Therefore, we must accept the null hypothesis at this significance level. Specifically, the analysis revealed that factors such as sex, age, educational attainment, and the schools from which the nurses graduated do not influence their ecumenical spiritual care practices. For example, the p-values for sex (0.627), age (0.329), and educational attainment (0.810) all suggest a lack of significant correlation. Similarly, although the chi-square value for religion (7.914) was higher, the p-value of 0.442 indicates that religious affiliation does not significantly impact how nurses incorporate spiritual care into their practice. With p-values of 0.954 and 0.802, respectively, workload variables—including patient count per shift and shift timing—also showed no meaningful correlations. These results imply that personal beliefs and practices rather than demographic or professional factors probably influence the integration of spiritual care among nurses. This underscores the idea that spiritual care can be embraced across diverse backgrounds and experiences within the nursing profession.

4. Discussion

Spiritual care is essential to holistic nursing because it considers patients' emotional, mental, and spiritual well-being. This study's results tell us a lot about how nurses currently provide spiritual care, how they think about it, and the problems they face. This combines the study's findings with other research, showing where they agree and disagree and what this means for nursing practice, education, and policymaking.

I. Profile of the Respondents

The demographic profile of nurses in this study highlights essential aspects that influence their ecumenical spiritual care practices. Gender, age, educational background, workload, and religious beliefs shape the delivery of spiritual care. By acknowledging and addressing these factors, healthcare institutions can better support nurses in providing holistic care that recognizes the vital role of spirituality in the healing process. This alignment benefits patient outcomes and contributes to nurses' professional growth and satisfaction, fostering a more compassionate and effective healthcare environment.

The findings reflected a well-documented trend in the nursing profession. This gender disparity, as noted by Buchan et al. (2019), is a global phenomenon where women dominate the field. The implications of this are multifaceted; female nurses often bring unique perspectives and approaches to patient care, which can enhance holistic and spiritual care delivery. The age distribution shows that most nurses fall within the 20-35 age bracket. This demographic is typically characterized by a willingness to adopt innovative practices, including holistic approaches to care. Bournes (2020) highlights that younger nurses are often more open to integrating modern methodologies into their practice. This receptiveness is crucial for the successful implementation of ecumenical spiritual care, as younger nurses may prioritize patient-centered approaches that recognize the importance of spirituality in healing.

In addition, the majority of the respondents hold a Bachelor's degree, and the educational background of the nursing staff is promising. Higher educational attainment in nursing is associated with improved patient outcomes and the capability to integrate complex care practices (Benner et al., 2010). This level of education indicates that the nurses are equipped with the knowledge and skills necessary to incorporate spiritual care into their holistic practice, potentially enhancing the overall quality of care. The data indicates that many nurses reported handling 11 to 20 patients per shift, with nearly half working 8-10 hour shifts. These workload demands can pose significant challenges to the effective delivery of holistic care. Dall et al. (2015) emphasize that high patient loads often lead to burnout and diminished care quality, underscoring the need for adequate staffing and supportive environments. Addressing these workload issues is essential for enabling nurses to engage fully in spiritual care practices without compromising their well-being or that of their patients. The predominance of Catholic nurses suggests that personal beliefs may significantly influence their approach to spiritual care. Research by Puchalski et al. (2014) indicates that a nurse's faith can shape their interactions with patients and inform their practice.

II. Ecumenical Spiritual Practices

2.1 General Manifestation in Rendering Spiritual Care

The results revealed that nurses prioritize understanding their patients' religious beliefs, which is fundamental in providing holistic care. This practice demonstrates an awareness that spirituality can significantly impact health outcomes and patient experiences. According to Koenig et al. (2012), recognizing religious artifacts in a patient's environment can facilitate spiritual assessments and discussions, reinforcing the importance of a supportive care environment. This recognition helps nurses to validate and respect patients' beliefs, promoting emotional well-being. Spiritual assessment tools are often practiced, indicating a commitment to systematically addressing spiritual needs. However, the slightly lower score suggests that consistent application could be improved.

Holt et al. (2015) highlight that using standardized spiritual assessment tools is crucial for effectively identifying patients' spiritual needs. These tools can help healthcare providers deliver comprehensive care incorporating spirituality, ultimately improving patient satisfaction and health outcomes. Furthermore, nurses actively incorporate the hospital's mission and vision related to spiritual care into their practice. This connection reinforces the organizational commitment to holistic care. Benner et al. (2010) argue that a precise alignment between personal practice and organizational values is essential for promoting a culture of holistic care. When nurses feel that their spiritual care practices align with their institution's mission, they are more likely to engage deeply with their patients' spiritual needs.

The findings reflect nurses' strong commitment to practicing ecumenical spiritual care. The high mean scores indicate that nurses recognize the importance of spirituality in patient care and actively incorporate it into their practice. However, the data also highlight areas for further improvement, particularly in consistently applying spiritual assessment tools. By creating an environment that supports these practices and ensuring ongoing education, healthcare organizations can enhance the delivery of holistic, patient-centered care.

2.2 General Manifestation in Rendering Spiritual Care

The findings revealed a strong integration of specific ecumenical spiritual practices among nurses, highlighted by high mean scores across all items. This suggests that nurses understand the importance of spiritual care and actively engage in practices that support patients' spiritual needs. Furthermore, nurses demonstrate a commitment to responding promptly to requests for spiritual services, such as anointing and blessings. This proactive approach is crucial for holistic care, as timely spiritual interventions can provide comfort to patients and their families during critical moments, thereby improving overall patient satisfaction (McCaffrey et al., 2012).

Additionally, nurses often engage in silent prayers for terminally ill patients, underscoring the significance of spirituality in end-of-life care and offering emotional support to both patients and their families. Coyle et al. (2010) highlight that effective communication is essential in spiritual care, enabling healthcare providers to understand and address the spiritual dimensions of patients' experiences. The findings also indicate that nurses prioritize creating private spaces for prayer, which is essential for respecting patients' spiritual practices. Research by Ferrell et al. (2016) suggests that providing such spaces enhances patients' spiritual well-being, allowing them to engage in meaningful rituals. Nurses also demonstrate awareness and respect for dietary restrictions based on patients' faiths. This practice shows cultural competency and respect for their beliefs. Hodge (2017) states that honoring dietary preferences is crucial for providing holistic care, positively impacting patients' spiritual and emotional well-being.

Overall, the findings reflect a strong commitment among nurses to integrate specific spiritual care practices into their daily routines. The high mean scores across all items demonstrate a holistic approach that addresses patients' spiritual needs. However, there is a need to focus on improving the documentation of spiritual care, ensuring that these vital practices are recognized and supported within healthcare settings. By continuing to foster an environment that values and integrates spiritual care, healthcare organizations can enhance the quality of patient care and contribute to a more compassionate and holistic healing process.

2.3 Recipients of Spiritual Care

Empathizing with patients and being sensitive to non-verbal cues indicates that nurses recognize the importance of emotional intelligence in spiritual care. Benner et al. (2010) assert that empathy and attentiveness to non-verbal communication are essential for nurses to deliver effective spiritual care. However, documenting spiritual care shows a need for improvement in recording these practices. While nurses are engaged in spiritual care, consistent documentation is crucial for maintaining continuity and quality of care. Holt et al. (2015) argue that documenting spiritual care ensures that these needs are recognized and addressed throughout the patient's healthcare journey.

Generally, the findings reflect a strong commitment among nurses to integrate specific spiritual care practices into their daily routines. The high mean scores across all items demonstrate a holistic approach that addresses patients' spiritual needs. However, there is a need to focus on improving the documentation of spiritual care, ensuring that these vital practices are recognized and supported within healthcare settings. By continuing to foster an environment that values and integrates spiritual care, healthcare organizations can enhance the quality of patient care and contribute to a more compassionate and holistic healing process.

2.4 Venue for Rendering Spiritual Care

The data indicates that nurses have a strong consensus regarding the venues for delivering spiritual care. This suggests that nurses believe spiritual care is integral to patient well-being and can be effectively administered in various settings, including patient rooms and peaceful environments. The importance of a silent and quiet environment highlights the need for tranquility during spiritual practices. This aligns with the literature emphasizing that environments conducive to meditation and reflection significantly enhance the quality of

spiritual care (Koenig, 2012).

The strong agreement that spiritual care can be rendered in a patient's room suggests that nurses recognize the importance of accessibility in delivering holistic care. Research indicates that familiar environments can alleviate anxiety and promote healing (Seymour et al., 2017). Nurses' ability to integrate spiritual care into daily interactions in patient rooms can strengthen the nurse-patient relationship, enhancing trust and emotional support (Dossey et al., 2016). Although the mean score for the preference for spiritual care in a chapel or prayer room is lower than other items, it still indicates recognition of specialized spaces for spiritual practices. This finding aligns with the perspective that designated spaces for spiritual reflection can provide patients with a more profound sense of peace and connection (Baldacchino, 2006).

The overall findings demonstrate a robust integration of spiritual practices among nurses. The data shows a strong consensus among nurses regarding the venues for spiritual care. The mean scores indicate that nurses believe spiritual care can be provided effectively in various settings, emphasizing the importance of privacy, a peaceful environment, and the possibility of providing care directly in patient rooms. The preference for a chapel or prayer room is acknowledged but slightly less in agreement than other venues. Overall, the category mean reflects a solid agreement with integrating spiritual care practices in their nursing roles.

2.5 Appropriate Time in Rendering Spiritual Care

The results showed that nurses know the suitable moments for offering spiritual care. This demonstrates a persistent conviction that spiritual care is vital and should be included in several phases of patient contact. The highest mean score for offering spiritual care during patients' lowest points shows that one understands the need to attend to spiritual needs during crises.

Conversely, tending to patients when calm and ready to listen emphasizes the need for patient receptivity in spiritual care. The result that every nurse-patient interaction incorporates spiritual care points to a comprehensive approach to nursing care. This reflects the developing knowledge that spiritual care should not be a separate activity but a component of nurses' regular contact with patients (Dossey et al., 2016). A high score for offering spiritual care during an emergency emphasizes nurses' vital role in attending to the spiritual needs of patients confronted with uncertainty. Studies show that spiritual care can help patients manage anxiety and worry and offer comfort and support in trying circumstances (Koenig, 2012). Giving spiritual care in the morning as part of a daily ritual shows the need to realize that spiritual care is necessary for nursing. Regular spiritual care might help patients feel stable and consistent (Baldacchino, 2006).

Overall, the results show that nurses are sensitive to the need for timing in delivering spiritual care by recognizing moments of need, readiness, and routine interaction. This enables the effective integration of spiritual practices into their treatment, improving the overall support given to patients.

2.6 Relevance/meaning of Spiritual Care

The results indicate a strong consensus among nurses regarding the importance and significance of spiritual care in nursing practice. Each aspect illustrates a solid understanding of how spiritual care relates to patients' beliefs, emotional support, and holistic nursing. The highest mean score for respecting patients as human beings shows that nurses prioritize the dignity and individuality of each patient. This finding aligns with research that emphasizes the importance of recognizing a patient's inherent worth as fundamental to effective spiritual care (Dossey et al., 2016). In contrast, the lowest mean score related to using counseling and therapeutic communication suggests that while nurses recognize the importance of dialogue in delivering spiritual care, there is room for improvement. Overall, the findings demonstrate that nurses possess a profound understanding of the significance of spiritual care in their practice. By emphasizing respect for patient beliefs, the value of therapeutic communication, and the integration of compassion and empathy, nurses show their commitment to providing holistic care that addresses the spiritual needs of their patients.

2.7 Institutional Support

The results highlight the role of institutional support in integrating ecumenical spiritual practices in nursing care. Nurses agreed on the importance of various institutional resources and practices facilitating spiritual care. The highest mean score indicates that nurses see the chapel or prayer room as essential for spiritual care. This aligns with literature suggesting that dedicated spaces for spiritual reflection can significantly enhance patients' spiritual experiences (Baldacchino, 2006). While the score for having a built-in speaker for daily mass is the lowest, it still acknowledges the importance of making spiritual resources accessible to patients. The findings demonstrate that nurses recognize the importance of institutional support in delivering effective spiritual care. Nurses can enhance their patients' spiritual well-being by valuing resources such as dedicated spaces, assessment tools, and religious support, reinforcing spirituality's integral role in holistic nursing practice.

III. Test of Significant Relationship Between the Ecumenical Spiritual Practices of Nurses and their Profile

The findings suggest that ecumenical spiritual practices among nurses are not significantly influenced by demographic profile variables such as sex, age, educational attainment, religion, and workload. This indicates that ecumenical spiritual practices may be more related to or attributed to other external factors associated with the nurses' profiles. The strong recognition of spiritual care's relevance and meaning reflects an evolving understanding of holistic nursing. The findings support the notion that spiritual care is not merely an adjunct to physical care but a fundamental aspect of holistic nursing practice. While the results showed no significant correlations between institutional support and spiritual practices, the nurses' acknowledgment of the necessity of supportive resources—like prayer rooms, assessment tools, and chaplain services—highlights an area for potential development. Institutions promoting spiritual care resources may enhance nurses' ability to deliver such care effectively. This aligns with the literature suggesting that institutional culture and resources significantly impact nurses' capacity to provide holistic care (Dossey et al., 2016).

5. Conclusions and recommendations

In light of the findings, the following conclusions are drawn: Most respondents are female, which aligns with the global trend of nursing being a predominantly female profession. The age group of 31-35 years suggests a population with sufficient professional experience to understand the importance of spiritual care. The educational attainment of bachelor's degree holders reflects a strong foundation in nursing education, equipping respondents with the knowledge and skills to incorporate spiritual care into their practice. Their graduation from private sectarian (Catholic-Christian) institutions and their Catholic faith may further enhance their understanding and application of spiritual care, as these institutions often emphasize values-based education and holistic care. In addition, managing 11-20 patients per shift and working 8-10 hours indicates a demanding environment. This demographic profile suggests that their personal, educational, and professional backgrounds collectively influence their capacity and willingness to engage in ecumenical spiritual practices within the hospital setting. The findings indicate that nurses consistently practice and value the importance of spiritual care across multiple dimensions. This infers a strong commitment among nurses to integrate spiritual care into their practice, highlighting its significance in holistic healthcare. By addressing the implications of these findings, healthcare institutions can foster a supportive environment that improves both patient outcomes and nurses' job satisfaction. The findings suggest that ecumenical spiritual practices among nurses are not significantly influenced by demographic variables such as sex, age, educational attainment, religion, and workload. This implies that the practice of ecumenical spirituality transcends individual demographic differences and may instead be shaped by external factors such as institutional culture, workplace policies, availability of spiritual care resources, professional training, and other factors.

Based on the conclusions mentioned above, the following recommendations are derived and suggested for possible implementation: The less frequent use of checklists or evaluation instruments for spiritual needs

suggests room for development. By means of standardized tools, nurses may methodically recognize and meet patients' spiritual requirements, guaranteeing consistency and comprehensiveness in the provision of spiritual care. The results highlight the need for focused professional development programs, including seminars or training courses, to support documentation integration into daily nursing care and the relevance of sincerity in spiritual contacts. The results emphasize the need for focused training programs to improve nurses' competencies in spotting and attending to spiritual requirements across a wider spectrum of patient situations, particularly for individuals suffering psychological discomfort. While encouraging the freedom to deliver treatment in patient rooms or other private areas, healthcare facilities should also consider improving or establishing specific venues for spiritual care, such as meditation rooms or silent areas. Policies and rules can help guarantee that these areas are open and encourage many spiritual needs. Particularly in high-stakes or emergency situations, hospital and nursing managers might use these insights to create training programs that improve nurses' capacity to recognize and meet spiritual needs. Furthermore, institutionalizing this practice involves developing procedures for regular spiritual care delivery. The findings will help the hospital create initiatives that highlight the need for respect and compassion in spiritual care and offer counseling methods and therapeutic communication training. Policies supporting the regular incorporation of spiritual activities also help guarantee consistency in the provision of treatment. The hospital should prioritize maintaining easily accessible chapels or prayer rooms and ensure they are ready to satisfy patients' spiritual needs and those of their families. The hospital should develop and apply spiritual care evaluation instruments to enable nurses to meet spiritual needs. Religious blessings or similar practices can be institutionalized as optional components of care, respecting the diverse faiths of patients. Providing resources like religious leaflets and exploring alternative ways to make spiritual content (e.g., online or recorded services) accessible could enhance spiritual care offerings.

6. References

Balboni, T. A., Fitchett, G., Handzo, G., Johnson, K. S., Koenig, H. G., Pargament, K. I., Puchalski, C. M., Sinclair, S., Taylor, E. J., & Steinhauser, K. E. (2022). Spiritual care: A central domain of palliative care—Embracing the spiritual dimension of serious illness. Journal of Palliative Medicine, 25(1), 19-30.

Baldacchino, D. R. (2006). Spirituality and Nursing: A Review of the Literature. Journal of Nursing Scholarship, 38(1), 26-31.

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2010). Educating Nurses: A Call for Radical Transformation. The Carnegie Foundation for the Advancement of Teaching.

Bournes, D. (2020). Generational differences in nursing: An analysis of workforce trends. Journal of Nursing Management.

Buchan, J., Shaffer, F. A., & Catton, H. (2019). Policy brief: Gender in nursing now. International Council of Nurses.

Coyle, N., & Johnston, B. (2010). Improving communication in palliative care. Journal of Palliative Medicine, 13(7), 861-867.

Dall, T. M., Chen, Y. J., Seifert, R. F., Maddox, P. J., & Hogan, P. F. (2015). The economic value of professional nursing. Medical Care, 47(1), 97–104. https://doi.org/10.1097/MLR.0b013e3181844da8

Dossey, B. M., Keegan, L., & Guillen, D. (2016). Holistic Nursing: A Handbook for Practice. Jones & Bartlett Learning.

Ferrell, B. R., Munevar, C. M., & Borneman, T. (2016). Spiritual care: Integral to quality palliative care. Critical Care Nursing Clinics of North America, 28(4), 411–419. https://doi.org/10.1016/j.cnc.2016.07.007

Hodge, D. R. (2017). Spiritual assessment in social work and healthcare settings: A review of the literature. Social Work in Public Health, 32(5), 378–389. https://doi.org/10.1080/19371918.2017.1307310

Holt, L., Lafferty, D., & Hodge, G. (2015). Spiritual assessment in clinical practice: A review of the literature. Journal of Nursing Care Quality, 30(1), 83-89.

Koenig, H. G., King, D. E., & Carson, V. B. (2012). Handbook of Religion and Health. Oxford University Press.

Koenig, H. G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. International Journal of Psychiatry in Medicine, 43(2), 185-204.

McCaffrey, R., Ferrell, B. R., & Malloy, P. (2012). Spirituality and the patient experience: Exploring the role of spiritual care in enhancing patient satisfaction. Journal of Nursing Administration, 42(3), 146–152. https://doi.org/10.1097/NNA.0b013e318248090f

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. Journal of Palliative Medicine, 17(6), 642–656. https://doi.org/10.1089/jpm.2014.9427

Ramezani, M., Ahmadi, F., Mohammadi, E., & Kazemnejad, A. (2021). Barriers to spiritual care in nursing practice: A qualitative study. Journal of Holistic Nursing, 39(2), 127-136.

Seymour, J., Kumar, A., & Froggatt, K. (2017). Delivering quality care for patients in familiar environments: The role of place in holistic nursing practice. Journal of Holistic Nursing, 35(3), 207–214. https://doi.org/10.1177/0898010116675111