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NURSES' EXPERIENCES IN PROVIDING SPIRITUAL CARE OF PATIENTS WITH HEART FAILURE

Original Research

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A B S T R A C T

***Introduction**: Spirituality plays an important role in the physical health of patients with chronic diseases. This study aimed to explore the experiences of nurses in providing spiritual care to patients with heart failure (HF) in Indonesia. **Methods**: This study employed a descriptive exploratory design with a qualitative approach. Thirteen nurses from the cardiology unit were selected using purposive sampling. Data were collected through semi-structured interviews and field notes. Thematic analysis was conducted to analyze the data. **Results**: Five major themes emerged, including perceptions regarding spiritual care, the importance of meeting the spiritual needs of patients, implementation of spiritual care, obstacles in providing spiritual care, and nurses' hopes. Most participants associated spiritual care with religious practices. All participants believed that the spiritual needs of patients with HF must be met. However, spiritual care was still rarely implemented. Nurses commonly assisted patients in performing religious practices rather than addressing existential needs. The barriers to providing spiritual care originated from patients, nurses, and the availability of tools. The nurses hoped that specific personnel could provide spiritual care and that spiritual guidance activities in the hospital could be reactivated. **Conclusions**: Spiritual care remains a neglected aspect in the treatment of patients with HF. Facilitating religious practices is the primary intervention that fulfills the spiritual needs of patients with HF in Indonesia.Facilitating religious practices is a primary intervention that meets the spiritual needs of patients with HF in Indonesia.*

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INTRODUCTION

Spirituality plays an important role in the physical health of patients with chronic diseases. Patients with advanced-stage diseases commonly experience mental and spiritual, in addition to physical, problems (Park & Sacco, 2017; Pearce et al., 2012). Therefore, meeting the spiritual needs of these patients can be beneficial not only for the patients but also for nurses themselves (Carpenter et al., 2008; Janzen et al., 2019; Moosavi et al., 2019). It helps nurses promote comfort and a sense of peace and, ultimately, gain inner satisfaction (Moosavi et al., 2019). Furthermore, it has positive impacts on patients, including reducing depression, anxiety, and hopelessness; enhancing spiritual well-being and quality of life; and improving clinical symptoms (Abu et al., 2018; Clark & Hunter, 2018; Gonçalves et al., 2017; Weathers, 2018; Xing et al., 2018). Conversely, unmet spiritual needs among patients are associated with poor spiritual, emotional, and physical well-being (C. L. Park & Sacco, 2017; Pearce et al., 2012).

Spiritual needs are defined as the desires and expectations that humans have to find meaning, purpose, and value in their lives. These desires and expectations can be religious in nature; however, even individuals who have no religious faith or are not members of an organized religion possess belief systems that provide meaning and purpose to their lives (Murray et al., 2004). Nurses are encouraged to meet these needs, in addition to addressing patients' physical, emotional, and psychological needs, by providing spiritual care as part of holistic care (Jasemi et al., 2017). Holistic nursing care is a philosophy that originates from the notions of humanism and holism and guides the care patients receive. It refers to patient care centered on a shared understanding of their physical, psychological, emotional, and spiritual aspects. Furthermore, holistic care emphasizes the nurse–patient partnership as well as the negotiation of healthcare needs that facilitate healing (Jasemi et al., 2017). In the context of holistic care, each individual is viewed as more than the sum of his or her body components. The individual represents a unified whole of body, mind, and soul. Any change in an individual's life affects every element of that life and determines the quality of the overall existence (Papathanasiou et al., 2013).

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Spiritual care is considered an important component of holistic nursing. In nursing practice, it can be categorized into two main interventions: religious and nonreligious. Religious interventions focus on fostering a connection with God through religious practices. In contrast, nonreligious interventions include nurses' roles as effective communicators, showing respect to patients and families, and demonstrating enthusiasm and empathy toward patients (Zehtab & Adib-Hajbaghery, 2014). Reed's Self-Transcendence Theory was used to guide the theoretical framework of this research. Reed (1996) proposes that humans possess an awareness of near-death situations, including life crises. The life crisis experienced by patients with heart failure (HF) involves the feeling of being close to death due to various stressors that affect them, including changes in physical function, psychosocial disorders, and spiritual distress. These factors cause patients to experience vulnerability, which requires holistic treatment.

Nurses often find it challenging to provide spiritual care for patients with HF (Ponikowski et al., 2014; Wu et al., 2016). Unlike cancer, the course of HF is unpredictable, and the condition frequently leads to sudden death (Chen-Scarabelli et al., 2015). Patients with HF experience a range of symptoms such as shortness of breath, fatigue, chest pain, sexual dysfunction, and significant changes in body image, all of which can cause distress (Yu et al., 2017). Moreover, these patients commonly experience anxiety and depression as a result of their illness (Aburuz, 2018; Alhurani et al., 2015). The medical management of HF is sometimes ineffective; therefore, patients often seek complementary and alternative treatments to improve their condition, one of which is spirituality (Naghi et al., 2012). However, previous studies have shown that spirituality in patients with HF is closely related to their physical condition, as a decline in spirituality typically follows a deterioration in physical health (Murray et al., 2007).

Previous studies have explored the experiences of nurses and other healthcare professionals in various healthcare settings regarding the provision of spiritual care, including general hospitals (Musa, 2017; Nascimento et al., 2013; Reig-Ferrer et al., 2019; Wong & Yau, 2010), acute care units (Chew et al., 2016; Kurniawati et al., 2017; Veloza-Gómez et al., 2017; Willemse et al., 2018; Yingting et al., 2017), palliative care units (Siler et al., 2019; Tiew et al., 2013), hemodialysis units (Egan et al., 2014), and cardiac rehabilitation units (Hosseini et al., 2015). Most of these studies have shown that nurses and healthcare professionals hold positive attitudes toward spiritual care and understand its importance in supporting patients' healing and health (Chew et al., 2016; Egan et al., 2014; Kurniawati et al., 2017; Tiew et al., 2013; Willemse et al., 2018; Wong & Yau, 2010; Yingting et al., 2017). However, many have not implemented spiritual care in their daily practice, and some have failed to translate it into actual care activities (Chew et al., 2016; Egan et al., 2014; Kurniawati et al., 2017; Musa, 2017; Veloza-Gómez et al., 2017; Willemse et al., 2018). Nurses have stated that they lack sufficient knowledge about providing spiritual care to patients (Siler et al., 2019; Yingting et al., 2017). Moreover, they reported receiving little or no in-service training or education related to spiritual care (Egan et al., 2014; Hosseini et al., 2015; Siler et al., 2019).

According to the current qualitative literature, most studies have investigated the implementation of spiritual care in general patient populations (Nascimento et al., 2013; Reig-Ferrer et al., 2019; Wong & Yau, 2010). Only a few studies have explored nurses' experiences in providing spiritual care to specific patient populations, such as those with kidney disease (Egan et al., 2014), coronary heart disease (Kurniawati et al., 2017), and those undergoing cardiac rehabilitation (Hosseini et al., 2015). The unique spiritual journey of patients with heart failure (HF) requires comprehensive investigation. Existing studies on spiritual care among patients with HF have mainly focused on patients' perspectives. However, research exploring this issue from nurses' perspectives remains limited. Patients with HF often experience profound feelings of hopelessness, isolation, and abandonment by both healthcare professionals and God (Kimani et al., 2016; Murray et al., 2004; Ross & Austin, 2015). In addition, nearly 50% of patients with HF report unmet spiritual needs and express a strong desire to have these needs addressed with the support of healthcare professionals (Park & Sacco, 2017). Understanding how spiritual care is provided from the nurses' perspective is essential to balance the information obtained from patients' viewpoints, thereby contributing to improved patient care. Therefore, this study aimed to explore the experiences of nurses in providing spiritual care to patients with HF.

MATERIALS AND METHODS

Study Design

This study employed a descriptive exploratory design with a qualitative approach. Exploratory research addresses personal perspectives within natural settings and practices (Silverman, 2000). This design was chosen to gain a deeper understanding of nurses' experiences in providing spiritual care and meeting the spiritual needs of patients with heart failure (HF) during hospitalization.

Participants and Setting

This study involved nurses working in the cardiology unit of a government hospital in East Java, Indonesia. Participants were selected using purposive sampling. They were included in the study if they had worked in the cardiology unit for at least one year and were willing to participate in an interview. This timeframe ensured that participants had sufficient experience in their role. Nurses were excluded if they were uncooperative or did not have enough time for an interview. The lead author obtained a list of nurses and information about their shift rotations from the unit. Nurses who met the inclusion criteria were identified and invited to participate. In total, 14 nurses were eligible for this study. The lead author visited the nurses during their shifts to confirm their availability. However,

one nurse who was on duty and unable to allocate sufficient time for an interview declined to participate.

The characteristics of the study participants are presented in Table 1. A total of 13 nurses participated in this study. All participants were Muslim, and three were male. Participants were aged between 25 and 43 years. The group included the deputy head of the Intensive Coronary Care Unit (ICCU), four cardiac inpatient ward nurses, and eight ICCU nurses. Nine participants held a Diploma in Nursing, three held a Bachelor's degree in Nursing, and one held a Master's degree in Health Sciences. Three participants had worked in the cardiology unit for one year; two for two and three years, respectively; and six for four years. Eight participants had worked in the hospital for ten years or more, while the remainder had less than ten years of experience. The Cardiology Unit at this hospital is relatively new, having been established in 2016. Previously, patients with heart disease were distributed across different wards. Consequently, most nurses in this unit had fewer than five years of service at the time of the study. Participants were interviewed individually in their workplace. All interviews were conducted face-to-face under strict health protocols, involving only the participant and the researcher.

Data Collection

Semi-structured interviews were conducted in July 2020 by the lead author, who had previous experience and training in qualitative research. All individual interviews were digitally audio-recorded using two portable devices. In addition, the researcher made field notes during the data-collection process.

Demographic data were collected at the beginning of each interview. Participants were then asked open-ended questions such as "What do you think about spiritual care?" and were invited to describe their perceptions of spiritual care. To explore the importance of meeting the spiritual needs of patients with HF during hospitalization, participants were asked, "How important is it to meet the spiritual needs of patients with HF during hospitalization?" To investigate nurses' experiences in delivering spiritual care, the following questions were posed: "According to your experience here, how is the implementation of spiritual care for patients with HF?" and "Can you tell me what obstacles you faced in providing spiritual care to patients with HF?" In addition, the probing question "Can you tell me more about that?" was used to encourage participants to share further information..

Each interview was performed once and lasted approximately 45 minutes on average. Data collection continued until saturation was reached. All recordings were transcribed verbatim. During the interviews, observational data in the form of descriptive notes were also gathered.

Ethical Consideration

This study was approved by the Ethics Committee of the Faculty of Nursing, Universitas Airlangga (No. 1780-KEPK). All participants were informed about the study's aims and potential benefits, data-collection procedures, the right to withdraw from the study, and confidentiality. They subsequently provided written informed consent.

Data Analysis

Data were analyzed using thematic analysis, a method for identifying, interpreting, and reporting patterns (themes) in qualitative data (Braun & Clarke, 2006). The six steps followed were: (1) familiarization with the data through active reading and re-reading; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report (Braun & Clarke, 2006). Trustworthiness was ensured through credibility, dependability, confirmability, and transferability. Credibility was supported by presenting verbatim transcripts to participants when discrepancies arose. Participants were provided with clustered statements and selected thematic categories to validate whether these accurately captured their experiences. One participant provided feedback on wording errors and suggested corrections. The lead author revised transcripts accordingly and returned them to participants until consensus was reached. Furthermore, the lead author performed data triangulation using patient perspectives and relevant documents. Dependability was addressed through peer examination by other authors, who reviewed supporting data and documents to confirm the findings and provide an opportunity for external evaluation. Transferability was supported by presenting the research findings to professional readers to assess how the results might apply to other social contexts and situations.

RESULTS

The thematic analysis identified five themes as shown in Table 2., including perceptions regarding spiritual care, importance of meeting the spiritual needs of patients, implementation of spiritual care, obstacles to providing spiritual care, and hope of nurses.

Table 1. Characteristics based on gender, religion, education, years working in cardiology, and years working in hospital at unit of a governmental hospital in East Java, Indonesia 2020

Gender	Frequency (f)	Percentage (%)
Female	10	76.9
Male	3	23.1

Religion	Frequency (f)	Percentage (%)
Muslim	13	100
Education	**Frequency (f)**	**Percentage (%)**
Diploma in Nursing	9	69.2
Bachelor in Nursing	3	23.1
Master in Health Science	1	0.07
Years Working in Cardiology Unit	**Frequency (f)**	**Percentage (%)**
1 year	3	23.1
2 years	2	15.4
3 years	2	15.4
4 years	6	46.1
Years Working in Hospital	**Frequency (f)**	**Percentage (%)**
< 10 years	5	38.5
≥ 10 years	8	61.5
Total	**13**	**100**

Based on Table 1, the majority of respondents were female (10 respondents, 76.9%), all respondents (13 respondents, 100%) were Muslim, and almost all (9 respondents, 69.2%) held a Diploma in Nursing. Six respondents (46.1%) had worked in the cardiology unit for four years, and eight respondents (61.5%) had worked in the hospital for ≥10 years.

Table2. Themes generate from the study at unit of a governmental hospital in East Java, Indonesia 2020

Themes	Subthemes
Perceptions regarding spiritual care	Religiosity
	Support
	Transcendence
The importance of meeting the spiritual needs of patients	Critical condition of patients
	Reducing physical and emotional symptoms
	Religious obligations
Implementation of spiritual care	Neglected care
	Facilitating religious practice
	Encouragement
	External elements
The obstacles of providing spiritual care	Patients' attitude and condition
	Nurses' attitude
	Lack of tools
Hope of nurses	Need specific person
	Activation of spiritual guidance activity

Perceptions regarding spiritual care

The perceptions of nurses regarding spiritual care were categorized into three main subthemes: religiosity, support, and transcendence.

Most nurses' perceptions of spiritual care were primarily influenced by their religious beliefs. Because spirituality and religiosity are inseparable in the Islamic spiritual context, nurses often held overlapping perceptions of the meaning of spiritual care. They stated that spiritual care was closely related to religion, faith, and worship of Allah subhanahu wa ta'āla (SWT) [May He be praised and exalted].

> P2: Spiritual care is correlated with religion. Spiritual needs lead them (patients) to pray and recite the Qur'an and so on.
>
> P6: It correlated with the beliefs held and prayer according to one's belief.
>
> P7: In my opinion, spiritual care is about facilitating patients to pray based on their beliefs.

One nurse stated that spiritual care included encouraging and motivating patients. The nurse revealed that patients with HF are often sad and express feelings of despair about dying soon. Moreover, patients tend to worry about their illness, wish to go home immediately, and hope to die there.

> P8: Spiritual care is providing support to patients, encouraging recovery, and enhancing motivation.
>
> P8: ...continue to encourage so as not to cause despair and worry because it makes the patient

more anxious, ma'am. Patients are usually sad because they want to die. They want to go home and die there.... One nurse stated that spiritual care was perceived as an effort to help patients to be close to Allah SWT

May He be praised and exalted]:

P13: Spiritual care means that we help patients to be closer to Allah.

Importance of meeting the spiritual needs of patients

Nurses revealed that the spiritual needs of patients be met. It could be observed in following three subthemes: critical conditions of patients, reducing physical and emotional symptoms, and religious obligations.

The nurses believed that the condition of patients with HF is often critical. Hence, this is one of the important reasons why the spiritual needs of patients must be met. Moreover, the condition of patients with HF is terminal, as expressed in the following statements:

P1: In my view, the spiritual needs of patients with HF in the ICCU are essential because their condition is terminal. Yes. The patients have a serious condition, ma'am. The issue is, their life is at risk, ma'am.

P13: We should have calmed down spiritually. Okay, maybe they look good physically, but we do not know what is inside. At any time, they can die, right? Like yesterday, there was a case in which the patient looked good, and it was time to transfer him to the ward. However, the patient had a heart attack and eventually died. Hence, spiritual care is important.

The nurses also expressed that spiritual care could reduce physical and emotional symptoms, such as anxiety, shortness of breath, and promote healing. Below is a statement of one of the participants:

P11: It is very important! You see, we are currently in a pandemic, right? If patients are not accompanied by prayer and worship, then they can experience stress and overthink. If patients do not calm down, healing will take time. If they are stressed, relapse can occur. Hence, it is important to promote healing by providing spiritual care.

Furthermore, the participants revealed that meeting the spiritual needs of patients is religious obligation. In Islam, performing the five daily prayers is an obligation of Muslim, regardless if they are in health or sickness. Hence, nurses believe that these needs should be fulfilled to meet religious obligations. Here is a statement of one of the participants:

P13: In my opinion, spiritual care is critical, particularly since prayer is an obligation of Muslims. If it is obligatory, it is a must, even though we are sick. There is a relief if you cannot stand, then sit. If you still cannot do it, you do it with eye signals. We as health workers here should remind the patients of their obligation to God.

Implementation of spiritual care

Nurses rarely implemented spiritual care among patients with HF in their daily routine. In addition, most of them assumed that providing spiritual care was only correlated to facilitating their religious practice. This study identified four subthemes, including neglected care, facilitating religious practice, encouragement, and external elements.

Nurses did not frequent provide spiritual care based on their knowledge. Moreover, they had a spirituality assessment form in the medical record. However, this was rarely filled out because they were more focused on physical/biological needs. Below are some of the statements of nurses:

P9: It is not yet performed daily. There is no routine assessment. We only have an assessment format. It is just a format. It is rarely done.

P2: Nurses do not perform an in-depth spiritual assessment. We focus more on the biological aspect.

Out of the rare implementation of spiritual care, there were some activities that the nurses did to meet the spiritual needs of patients with HF. The nurses reminded the patient about the five obligatory prayer times, either based on the initiative of nurses or at the request of patients. Here are some of the statement examples:

P13: Mmm... I remind the patient of prayer times, usually the time for dhuhr prayer. Regardless if it was implemented or not, the important thing is that we have reminded.

P10: While I am wiping, the patient asked "What time is it, nurse? already adhan [call to prayer]?" "Yes, ma'am. If you want to pray, go ahead." I answered. Sometimes, I also remind the patient about the prayer times.

The nurses also reminded the patients to perform remembrance (dhikr) and du'a (supplication) when some treatments were delivered or when their conditions deteriorate. Some of the statements of participants are as follows:

P1: For example, when the patient has specific treatments, such as when the patient was provided with a thrombolytic drug, we remind the patient to pray and dhikr while the medicine is administered, ma'am.

P6: If I want to perform any procedures, for example, every time I want to administer medications via IV infusion, I provide health education to the patient. It usually hurts, right? I remind the patient, "Sir, please pray, bismillah,"

P7: Sometimes, if the patient is in pain, whether it caused by shortness of breath or chest pain, I say "Sir, please pray as much as you can.

Furthermore, the nurses helped patients to worship by providing water spray for ablution and Al-Qur'an for recitation.

P10: We had time to provide water for spray. We usually help patients who want to pray using

water for ablution. Some patients use tayammum too.

P7: We facilitate patients with the Al-Qur'an in this ward.

A small number of nurses provide encouragement and motivation, which are other forms of providing spiritual care to patients with HF. The nurses encouraged the patient to remain calm and to let go of any despair and stress. This was performed by nurses while providing care to patients.

P9: Continue to encourage patients not to feel any despair and worry too much.

P1: We tell the patient to be calm and relaxed and avoid overthinking. During nursing care, while we talk about the problem, we try to calm down the patient.

External elements are involved in spiritual care among patients with HF. These included the presence of religious leaders and family. Religious leaders, such as Modin (for Muslims) and Pastor (for Christians), were included based on the request of the patients' family and the initiative of the patient's own family. They played a role in praying for patients when they were sick, particularly when they were dying. Moreover, nurses encourage the family to be involved in helping patients meet their spiritual needs, particularly at critical times, by talkin (naming the patient with the sentences of thoyyibah [the holy sentences in Islam, e.g., Laa ilaaha illallahu]). Talkin is commonly delivered to the patients when they were in Sakarat al-mawt. This is a condition of unconsciousness when someone is about to die, which signals someone's death.

P3: In one case, there was a family member who asked to be connected, and the Modin is here to recite Quran or something.

P2: If the patient is Christian, a Pastor comes. He asked permission to pray for the patient.

P1: Commonly, when the patient's condition is critical. A family member is informed to enter the room and is provided with a chair next to the patient's head. Hence, we focus on saving the patient's life. For example, when we perform cardiac resuscitation on patients, the family member can continue provide talkin to the patient.

Obstacles in providing spiritual care

The study findings in Table 3 show that both variabSome of the obstacles in providing spiritual care for patients with HF come from patients, nurses, and tools. These three subthemes are described as follows:

The obstacles from the side of patients were mainly their attitude and condition. The attitude of patients was more likely to be trivial, and they did not trust the nurses, and were less cooperative. Moreover, they were influenced by their spiritual background. In addition, the other obstacle was the condition of patient itself. Most inpatients with HF were unstable. They are also attached to several medical tubes, thereby interfering with their activities. Here are some of the statements:

P9: If he has an excellent religious basis, he will be carried away, ma'am. However, if the previous habits were not good, sometimes they are reminded that there is no response, and they are not cooperative.

P6: Sometimes, if the patient was short of breath, he did not pay attention to what the nurse was saying. He was busy with his tightness. Hence, only family can pray.

P12: The patients were commonly installed by more than one infusion, such as syringe pump and infuse pump, and others. Hence, it is hard to do ablution. Maybe tayammum is more appropriate if the patient wants it. Maybe that is the problem.

Meanwhile, from the perspective of nurses, several attitudes inhibit the provision of spiritual care, including the lack of discipline, lack of control from the supervisor, only focusing on the physical needs of patients, and being afraid to make a mistake.

P13: There was a spray for the patient's ablution before. Nevertheless, now, it has been lost because of a lack of control, ma'am. We more focused on his physical health. Hence, we neglect to do what is mandatory

P1: I never ask about the patient's spirituality, ma'am because I was worried that it is not proper to ask about those issues [smiling].

P2: I hesitate to offer prayers to patients. I am afraid that the patient will be offended, although not all of them.

The obstacles from the tools are attributed to the absence of standard operational procedure and lack of supporting facilities for providing spiritual care, such as ablution and tayammum kits.

P13: There is no standard operational procedure for actions related to spiritual care. There is only a spiritual assessment form.

P8: There is no ablution and tayammum kit in this ward. Previously, there was a sprayer. However, currently, it is not used.

Hope of nurses

The expectations of nurses regarding the implementation of spiritual care in hospitals, particularly among patients with HF, include the need for specific persons to provide spiritual care and activate the spiritual guidance activities, which is called Bimbingan Rohani (Binroh). Here are the examples of the expressions of nurses:

P7: I think we need a particular officer regarding religion or spirituality. When the patient was unconscious, the officer directed the patient's family. Whenever there is a new patient, he comes here or every day or at certain hours.

P10: Then, spiritual guidance should be implemented. It is offered but not to all patients. In a private Islamic hospital, spiritual guidance

may be offered during each morning shift in the form of a consultation or delivering tausiyah (short broadcast of da'wah) or whatever. However, there is none here (in the governmental hospital). Hopefully, this hospital will soon implement spiritual guidance for patients.

DISCUSSION

The present study aimed to explore the experiences of nurses in meeting the spiritual needs of inpatients with HF in a cardiology unit. Previous studies have discussed spiritual care in various populations and healthcare settings. However, to the best of our knowledge, this is one of the first studies to focus on the spiritual care of patients with HF from nurses' perspectives. Based on the findings, five major themes describe spiritual care for patients with HF during hospitalization in Indonesia.

Perceptions regarding spiritual care

With regard to how nurses perceive spiritual care, we found that participants' understanding of its meaning varied. This finding is consistent with previous studies that also examined nurses' perceptions of spiritual care, revealing diverse interpretations and some continuing confusion about its definition (Cooper et al., 2020). In this study, most nurses stated that spiritual care was correlated with religiosity. This association reflects their religious background—all participants were Muslim. In Islamic teaching, there is no dichotomy between religiosity and spirituality; religiosity serves as the framework for achieving spirituality. Islamic spirituality is grounded in religious practice, with an individual's relationship with Allah as its central focus. Therefore, many Muslims believe that their religious faith and spirituality overlap (Ahmad & Khan, 2016).

One nurse also perceived spiritual care as a form of emotional support. The nurse explained that patients with HF often experience emotional and psychological distress related to their illness. Previous studies have similarly shown that depression and anxiety are common among patients with HF (Aburuz, 2018; Alhurani et al., 2015). Providing emotional support is recognized as a type of compassionate care (Puchalski et al., 2014). This aligns with findings from a study in Colombia, which revealed that spiritual care includes emotional support, open-mindedness, and active listening (Veloza-Gómez et al., 2017). Spiritual care begins with promoting human interaction through compassionate engagement and responding to individual needs (Jackson et al., 2016). For terminally ill patients, particularly those with HF, spiritual needs often center on fear of dying, changes in role function, and loss of a sense of self. Importantly, such patients wish to be involved in their healthcare decisions (Westlake et al., 2008). Thus, spiritual care helps patients with HF address their unmet needs compassionately through emotional and psychological support.

Some nurses in this study also viewed spiritual care as an effort to help patients draw closer to God, which aligns with the concept of transcendence. Spiritual care is a subjective and dynamic concept—an integral dimension of holistic care that encompasses all others. It emerges from the nurse's awareness of the transcendent aspects of life and reflects the patient's lived reality (Ramezani et al., 2014). The idea of "getting closer" identified in this study is comparable to the notion of connectedness found in a previous study exploring nurses' perceptions of spirituality in Hong Kong. One participant in that study described spirituality as "connectedness with everything that has power above all of us" (Wong & Yau, 2010). However, the difference in this context lies in the specificity of connection: in Islamic spirituality, connectedness refers to a close relationship with Allah subhanahu wa ta'ala (SWT) [May He be praised and exalted], the God worshiped by Muslims. This closeness is expressed through acts of worship performed to seek the grace of Allah. Hence, the nurses in this study believed that spiritual care involves facilitating acts of worship as an intervention to strengthen patients' closeness to God. This differs from the broader concept of connectedness reported in other studies, which typically refers to a general sense of unity with a higher power or force beyond humanity.

Importance of meeting the spiritual needs of patients

Most participants revealed that meeting the spiritual needs of patients with HF was essential. One reason was related to the physical condition of these patients. Several participants stated that patients with HF often experience terminal conditions, as many are hospitalized due to worsening chronic HF (Gheorghiade & Pang, 2009). Common symptoms include shortness of breath, edema, pain, fatigue, depression, and gastrointestinal distress (Alpert et al., 2017). Patients with HF have an unpredictable disease course, marked by periods of stability interrupted by acute exacerbations and, at times, sudden death. Many patients are confused and anxious about the nature of their illness, its treatment, and their prognosis (McIlvennan & Allen, 2016). Therefore, spirituality serves as a vital source of hope and a means for patients to cope with their illness effectively (Gillilan et al., 2017). In the context of Islamic spirituality, preparing patients with good spirituality is particularly critical for those nearing death, as a Muslim's highest hope is to die in a state of husnul khotimah—a beautiful end to life under Allah's grace and pleasure. Nurses who are aware of this need often help facilitate it by asking patients' family members to recite surahsfrom the Qur'an and remind the patient to engage in dhikr by reciting the declaration of faith (shahadatain) (Marzband et al., 2016).

Several nurses also mentioned that providing spiritual care could help reduce physical and emotional symptoms while enhancing healing among patients with HF. This finding aligns with previous studies that explored nurses' perceptions of the benefits of spiritual care. Spiritual care helps patients achieve greater physical and psychosocial comfort. Patients

often experience less pain when praying to God and report reduced anxiety after meditation (Wong & Yau, 2010). Previous studies involving patients with HF have also supported these findings. Anxiety has been found to be inversely correlated with spiritual well-being (Johnson et al., 2011), and higher spirituality levels are associated with a lower risk of depression regardless of patients' general health (Bekelman et al., 2007; Mills et al., 2015). Furthermore, studies on the physiological effects of prayer show that those who pray exhibit lower respiratory and heart rates, reduced blood pressure, greater peripheral perfusion, and slower brainwave activity—indicating a hypometabolic state. These physiological responses contrast with the vasoconstriction and hypermetabolic effects commonly seen in patients with HF, suggesting that prayer may offer beneficial effects (Naghi et al., 2012).

In addition to the patients' physical conditions and the beneficial effects of spiritual care, religious obligation emerged as another important reason for meeting the spiritual needs of patients with HF. One participant mentioned that prayer (Allah), a central spiritual practice in Islam, is obligatory for every Muslim. Based on Islamic teachings, Muslims are required to perform the five daily prayers in all circumstances—whether in health or sickness, even during times of war. As stated in the Qur'an, "Indeed, I am Allah. There is no deity except Me, so worship Me and establish prayer for My remembrance." [(Shahih International, 2021), 20:14]. The Prophet Muhammad (peace be upon him) also said, "Pray standing up; if you cannot do it, then pray sitting down; and if you cannot, then pray lying on your side." (Narrated by Al-Bukhari). For patients, prayer becomes even more meaningful during illness than at any other time. When individuals are confronted with hardship, they seek refuge and return to God (Marzband et al., 2016). As the Qur'an reminds, "And when adversity touches man, he calls upon his Lord, turning to Him; then when He bestows on him a favor from Himself, he forgets Him whom he called upon before..." [(Shahih International, 2021), 39:8].

Implementation of spiritual care

Spiritual care was rarely implemented in the participants' daily nursing activities. Spirituality has become a neglected aspect among the dimensions of care. The nurses in this study tended to focus more on biological needs rather than psychological or spiritual ones. Similar findings have been reported in previous studies conducted in different settings and populations (Egan et al., 2014; Musa, 2017; Kurniawati, Nursalam, & Suharto, 2017; Willemse et al., 2018). According to the participants, psychosocial and spiritual issues were often deprioritized because physical conditions were perceived as more life-threatening. However, patients require nurses' assistance not only in addressing medical concerns but also in fulfilling their spiritual and emotional needs (Kurniawati et al., 2017). From the perspective of the holistic nursing paradigm, nursing care should encompass the needs of the mind, body, and spirit as an integrated whole (Carpenter et al., 2008). Moreover, patients with terminal conditions, such as HF, require special attention. As their conditions worsen, the focus of care shifts from curing the illness toward helping patients make the most of their remaining time (Ross & Austin, 2015). Therefore, addressing the spiritual needs of patients—alongside their physical and emotional needs—is of great importance.

The participants in this study stated that the spiritual care commonly provided to patients with HF was associated with religious practice. These practices included reminding patients about the five obligatory prayer times, encouraging dhikr (remembrance) and du'a (supplication), and providing water spray for ablution and copies of the Al-Qur'an for recitation. These spiritual care practices differ from those reported in a previous study of Jordanian Muslim nurses, where existential forms of spiritual care were more frequently provided than religious ones (Musa, 2017). They also contrast with findings from Colombia, where spiritual care in emergency settings focused more on therapeutic nurse–patient/family relationships (Veloza-Gómez et al., 2017). However, the present findings are consistent with a previous study on holistic care for ICU patients in Indonesia, in which religious practice was identified as the central form of spiritual care (Kurniawati et al., 2017). As previously discussed, in Islamic teaching, religious practice serves as a framework for attaining spirituality (Ahmad & Khan, 2016). Thus, by engaging in prayer, supplication, and dhikr (remembrance), patients are indirectly encouraged to seek meaning and purpose in life. This finding provides novel insight into the provision of spiritual care—within the Indonesian Muslim context, facilitating religious practice rather than existential engagement has become the primary form of spiritual care intervention.

In this study, another dimension of spiritual care involved external elements, including religious leaders and family members. Religious leaders refer to individuals competent in addressing religious matters apart from healthcare professionals. In the Indonesian context, they are known as Modin (for Muslims) and pastors (for Christians). These leaders play an important role in providing spiritual interventions such as praying, offering encouragement, and helping patients find meaning in their illness. This role is comparable to that of chaplaincy within the Judeo-Christian model of spirituality (Clark & Hunter, 2018; Donesky et al., 2020). However, the participation of religious leaders in the hospital setting remains suboptimal—particularly in government hospitals—because their presence typically occurs only upon request, rather than as a routine practice. Family members also play a significant role in providing spiritual care. Because nurses primarily focus on patients' biological needs, patients often rely on family members—such as spouses or children—to assist them with their spiritual needs. For example, family members help patients perform Allah (prayer), prepare for ablution or tayammum, and recite the Qur'an. When a patient's condition deteriorates, nurses

may ask family members to accompany them during sakarat al-mawt (the dying phase) by reciting verses from the Qur'an and performing talkin—the declaration of faith before death. This finding aligns with previous studies highlighting the significant role of family and significant others in fulfilling the spiritual needs and overall well-being of patients (Kurniawati et al., 2017; Veloza-Gómez et al., 2017).

Obstacles of providing spiritual care

This study identified three main obstacles associated with the provision of spiritual care. The first obstacle was related to the patients. Participants revealed that patients' attitudes and conditions often created challenges in delivering spiritual care. Some patients were occasionally uncooperative, which hindered nurses from providing adequate interventions. Moreover, the patients' religious backgrounds influenced their attitudes toward spiritual care. Therefore, a comprehensive assessment of each patient's spiritual or religious background is required before providing care. Such an assessment should include aspects of personal faith, spiritual contentment, and religious practice (O'Brien, 2014). Another obstacle was attributed to patients' physical conditions. Patients with HF are often attached to medical tubes and equipment, which restrict their ability to perform spiritual activities. Since prayer is the primary spiritual practice for Muslims—preceded by ablution or tayammum—patients frequently face difficulties performing these acts of worship when connected to medical devices such as syringe pumps, infusion pumps, and monitors. Islamic teachings provide relief for Muslims who are sick and unable to perform worship as usual. As stated in the Qur'an, "He has chosen you and has not placed upon you in the religion any difficulty." [(Shahih International, 2021), 22:78]. However, some patients are unaware of these forms of religious relief. Therefore, spiritual care in the form of spiritual and religious education is essential. Nurses need sufficient knowledge and additional training in spiritual and religious matters to effectively provide information and guidance to patients (Egan et al., 2014; Siler et al., 2019).

The second obstacle involves the nurses. The attitudes of some nurses hindered the provision of spiritual care. Major issues included a lack of discipline and insufficient supervision. The lack of discipline was associated with a low level of awareness among nurses regarding the importance of providing spiritual care for patients with HF. Moreover, nurses tended to focus more on physical aspects of care. A previous study showed that the frequency of providing spiritual care was positively associated with nurses' spiritual well-being (Musa, 2017). Another study also demonstrated that nurses' spirituality was significantly associated with their caring behavior (Bakar et al., 2017). When nurses possess stronger spiritual well-being, their caring behavior improves. Some nurses stated that they were afraid of making mistakes when communicating about spirituality with patients and felt awkward initiating such conversations. Therefore, before engaging in this aspect of care, nurses must first assess and reflect on their own spirituality, find ways to nurture it, recognize the purpose and significance of their profession, and intentionally build meaningful connections with their patients (Carpenter et al., 2008).

The third obstacle was the lack of tools, which involved the absence of standard procedures for conducting spiritual care and the lack of supporting facilities for performing ablution and tayammum. The nurses stated that they required clear guidelines for delivering spiritual care, particularly when the condition of patients with HF changed. Some nurses expressed confusion about what they should do regarding spiritual care when patients experienced shortness of breath or when their condition deteriorated. During episodes of shortness of breath, patients were often unresponsive and preoccupied with their discomfort. Therefore, standard operating procedures (SOPs) for the provision of spiritual care to patients with HF are essential. This finding is consistent with previous studies showing that providing nurses with adequate tools and training is important (Egan et al., 2014; Siler et al., 2019).

Hope of nurses

The participants expressed their desire for improvements in the provision of spiritual care, including the need for designated personnel to deliver and facilitate spiritual guidance activities in the hospital. In the Indonesian context, this role refers to religious leaders commonly known as Modin. This finding supports previous research emphasizing the importance of collaboration among nurses, family members, and chaplains or clergy in providing spiritual care, with adjustments made according to each religion (Herlianita et al., 2018). Furthermore, such collaboration introduces a new perspective on spiritual care, underscoring the nursing role in providing holistic care and highlighting the need for specialized providers who are more competent in addressing spiritual aspects (Donesky et al., 2020; Marzband et al., 2016).

CONCLUSIONS

Nurses perceive the meaning of spiritual care differently, with most attributing it to religious practice. All participants believed that it is important to meet the spiritual needs of patients with HF—both due to the terminal nature of the condition (to reduce physical and emotional signs and symptoms) and for religious obligations. Although spiritual care is still rarely implemented, nurses most commonly assist patients in carrying out religious rather than existential practices. Barriers to meeting the spiritual needs of patients with HF arise from three main sources: patients, nurses, and the lack of supporting tools. Participants expressed hope that specific personnel could be assigned to provide spiritual care and that spiritual guidance activities would be reactivated in the hospital. Overall, facilitating religious practice remains the primary intervention in meeting the spiritual needs of patients with HF.

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AUTHORS' CONTRIBUTIONS
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CONFLICT OF INTEREST
The authors declare that there is no conflict of interest.

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