

Original Article

Nurses' Perceptions of Spirituality and Spiritual Care in Clinical Practice: A Theory-Driven Correlational Study in Selected Hospitals in Laguna, Philippines

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Abstract. Spirituality and spiritual care are essential components of holistic nursing practice; however, existing studies remain largely descriptive and lack a clear theoretical explanation of how nurses' perceptions of spirituality translate into clinical care. This study aimed to examine nurses' perceptions of spirituality and their relationship with the delivery of spiritual care in selected hospitals in Laguna, Philippines. A quantitative descriptive-correlational design was employed among 227 registered nurses selected through purposive sampling. Data were collected using a validated self-developed questionnaire and were statistically analyzed. Findings revealed that the majority of respondents were aged 31–40 years, predominantly female, and Roman Catholic. Nurses demonstrated a very high level of spirituality ($M = 3.36$) and of spiritual care ($M = 3.36$). Most demographic variables showed no significant differences in spirituality and spiritual care, except for sex, which showed a significant difference in spiritual care ($p = .026$). Furthermore, a moderate positive and significant relationship was found between spirituality and spiritual care ($r = 0.431$, $p < .001$). These findings suggest that nurses' internal spirituality moderately influences their delivery of spiritual care, highlighting the importance of integrating spirituality into nursing education and clinical training. This study helps address the gap by providing a theory-driven, localized understanding of spirituality in nursing practice.

Keywords: *Clinical practice; Perception; Spiritual care; Spirituality.*

In healthcare, holistic care extends beyond addressing patients' physical needs to include their emotional and spiritual well-being. Spirituality, although deeply personal and multifaceted, plays a crucial role in how individuals find meaning, cope with illness, and maintain psychological resilience. In nursing practice, a nurse's perception of spirituality significantly influences the provision of holistic care, as factors such as culture, religion, education, and clinical experience shape how spirituality is understood and integrated into patient care (Sinaga et al., 2021). Given that nurses spend the most time with patients, they are in a unique position to provide spiritual support; however, their ability to do so varies with their knowledge, beliefs, and preparedness.

Existing literature highlights the positive impact of spiritual care on patient outcomes. Studies have shown that

patients whose spiritual needs are addressed report higher levels of satisfaction, improved coping mechanisms, and enhanced overall well-being (Harrad et al., 2019; Wei et al., 2024). Despite this, many nurses continue to feel uncertain or inadequately prepared to provide spiritual care due to limited training, fear of imposing personal beliefs, or lack of clarity regarding appropriate interventions. While some nurses demonstrate confidence in delivering spiritual care, others experience discomfort and difficulty in integrating spirituality into clinical practice, highlighting a gap in understanding how nurses' internal perceptions of spirituality are translated into actual care practices.

Much of the existing research (De Maria et al., 2022; Harrad et al., 2019; Sinaga et al., 2021; Wei et al., 2024) has focused on general attitudes toward spirituality rather than providing theory-driven explanations of how spirituality is integrated into nursing practice. More importantly, existing studies (Harrad et al., 2019; Sinaga et al., 2021; Wei et al., 2024) have not sufficiently explained the mechanisms by which nurses' perceptions of spirituality are translated into concrete spiritual care practices, nor have they integrated multiple theoretical perspectives to provide a comprehensive explanation of this relationship. This creates a gap in understanding not only whether spirituality influences care, but also how and why this influence occurs within nursing practice.

Specifically, existing studies remain limited in three critical aspects: (1) they are largely descriptive rather than theory-driven, (2) they fail to integrate multiple theoretical frameworks to explain the mechanism linking perception to practice, and (3) they do not clearly establish how nurses' internal spirituality systematically translates into observable spiritual care behaviors. Consequently, the current body of knowledge lacks a coherent, explanatory model that accounts for the relationship between spirituality and clinical practice.

In the Philippine context, particularly in San Pablo City, there is limited empirical and theory-driven research examining how nurses' perceptions of spirituality shape their clinical practice. Furthermore, no local study has explicitly integrated established nursing and spirituality theories to examine this relationship in a unified, theory-driven model. This highlights the need for a localized investigation that not only measures levels of spirituality and spiritual care but also explains the relationship between these variables within a clear conceptual and theoretical framework. Addressing this gap is essential to advancing knowledge on how spirituality can be effectively integrated into nursing practice.

This study is grounded in three complementary theoretical frameworks: Leininger's Transcultural Nursing Theory, Puchalski's Spirituality and Health Model, and Kolcaba's Theory of Comfort, which collectively provide a multidimensional understanding of spirituality in nursing practice. Leininger's theory explains how nurses' cultural background and personal beliefs shape their perception of spirituality, which serves as the independent variable in this study. This theory supports the inclusion of demographic variables such as religion, age, and clinical experience, as these factors influence culturally congruent care. Puchalski's model provides the mechanism linking perception to practice, emphasizing that spiritual awareness must be translated into intentional spiritual care interventions. This directly supports the study's dependent variable: the delivery of spiritual care. Kolcaba's Theory of Comfort further strengthens the framework by explaining how spiritual care contributes to patients' psychospiritual comfort through relief, ease, and transcendence.

Collectively, these theories establish a causal pathway in which nurses' perceptions of spirituality (influenced by cultural and demographic factors) shape their provision of spiritual care, ultimately contributing to holistic patient outcomes. This integrated framework guided the formulation of research questions, selection of variables, and choice of a correlational research design. Moreover, the study adopts a theory-driven, correlational approach in which theoretical constructs directly inform variable selection, hypothesis testing, and statistical analysis, strengthening the rigor and interpretability of the findings.

Specifically, this study seeks to answer the following research questions: (1) What is the demographic profile of the respondents in terms of age, sex, religion, type of school, years of practice, and area of practice? (2) What is the level of nurses' perception of spirituality? (3) What is the level of nurses' perception of spiritual care? (4) Is there a significant difference in perceptions of spirituality and spiritual care when grouped according to demographic profile? and (5) Is there a significant relationship between nurses' perception of spirituality and spiritual care? To address these questions, a quantitative descriptive-correlational design was employed among nurses working in selected hospitals in San Pablo City.

The findings of this study are expected to contribute to nursing education, clinical practice, and healthcare management by providing insights into how spirituality influences patient care, informing the development of targeted training programs, strengthening the integration of spiritual care in nursing curricula, and supporting healthcare institutions in promoting holistic and patient-centered care. More importantly, this study offers a theory-driven, context-specific contribution by integrating multiple theoretical frameworks to explain the relationship between spirituality and spiritual care, thereby moving beyond purely descriptive accounts toward a more explanatory, evidence-based understanding. Additionally, this study contributes localized, theory-driven evidence to the existing literature, helping bridge the gap between conceptual understanding and clinical application. While the findings are limited to selected hospitals, they provide a foundation for future research with broader populations. Ultimately, this study aims to advance the integration of spirituality in nursing practice, promoting care that is both compassionate and evidence-based.

Methodology

Research Design

This study employed a quantitative, descriptive-correlational research design, which is appropriate for examining relationships among variables without manipulating them. According to Sreekumar (2023), quantitative research involves the systematic collection of numerical data, often through structured instruments, and the application of statistical techniques to analyze patterns, relationships, and differences. The descriptive component aimed to systematically present the respondents' demographic characteristics and their perceptions of spirituality and spiritual care. The correlational component examined the relationships among nurses' demographic variables, their perceptions of spirituality, and their delivery of spiritual care. This design is widely used in nursing research to explore naturally occurring relationships in clinical settings and to generate evidence that can inform practice and policy.

Participants and Sampling Technique

A total of 227 registered nurses participated in the study out of 284 potential respondents. Participants were drawn from four hospitals in San Pablo City: Community General Hospital (n = 71), Laguna Provincial Hospital-San Pablo City District Hospital (n = 64), San Pablo City General Hospital (n = 60), and San Pablo Doctors Hospital (n = 32). Both male and female nurses who were actively engaged in direct patient care were included. The study utilized non-probability purposive sampling to ensure that participants met specific inclusion criteria relevant to the research objectives. Participants included registered nurses aged 20 years and older who were actively engaged in direct patient care; those assigned to administrative roles or not involved in direct patient care were excluded from the study.

Research Instrument

The study utilized a researcher-developed questionnaire written in English, consisting of three sections: (1) demographic profile (name – optional, age, sex, religion, type of school graduated, years in nursing practice, and area of practice), (2) nurses' perceptions of spirituality, and (3) delivery of spiritual care, comprising 20 items. A 4-point Likert scale was used, with response options ranging from Strongly Disagree to Strongly Agree for spirituality and Never to Always for spiritual care. The instrument was developed based on an extensive review of related literature to ensure that the items captured key constructs such as personal beliefs, meaning-making, and the integration of spirituality into clinical practice, consistent with the study's theoretical framework. The instrument was developed based on existing literature and guided by Puchalski's Spirituality and Health Model and Kolcaba's Theory of Comfort.

Content validity was established through evaluation by a panel of nursing and research experts, who assessed the clarity, relevance, and appropriateness of each item. Their recommendations were incorporated to refine the instrument. A pilot test was conducted among 30 nurses at St. Frances Cabrini Medical Center to assess reliability and clarity. The results yielded a Cronbach's alpha of 0.908 for the spirituality scale and 0.862 for the spiritual care scale, indicating excellent and good internal consistency, respectively. These findings confirm that the instrument is both valid and reliable for measuring the intended constructs.

Data Gathering Procedure

Prior to data collection, the researchers secured formal permission from both private (Community General Hospital and San Pablo Doctors Hospital) and government hospitals (Laguna Provincial Hospital-San Pablo City District Hospital and San Pablo City General Hospital), as well as from the research adviser and the Dean of the

College of Nursing. After obtaining approval, the researchers conducted face-to-face data collection, during which they clearly explained the purpose, objectives, and significance of the study to the participants. Informed consent was obtained before administering the questionnaire. Health and safety protocols were strictly observed throughout the data collection process. Completed questionnaires were retrieved, checked for completeness, and organized systematically. The data were then encoded and submitted to a statistician for appropriate statistical treatment. The processed results were returned to the researchers for analysis and interpretation.

Data Analysis Procedure

The collected data were analyzed using appropriate descriptive and inferential statistical methods. Frequency and percentage were used to describe the demographic profile of the respondents, while mean and standard deviation were used to determine the level of nurses' perceptions of spirituality and spiritual care.

While descriptive statistics summarized the data, the study primarily employed inferential statistical techniques to test hypotheses and examine relationships between variables, thereby enhancing analytical depth and allowing for generalization beyond the sample. The Mann-Whitney U Test and Kruskal-Wallis H Test were used to assess statistically significant differences across demographic groups, while Spearman's Rho was used to assess the strength and direction of the relationship between nurses' perceptions of spirituality and their delivery of spiritual care. Cohen's *d* was computed to determine the practical significance of findings, particularly with respect to sex, ensuring that results were not only statistically significant but also meaningful in clinical practice.

These inferential statistical procedures were aligned with the study's theoretical framework, in which nurses' perception of spirituality was treated as the independent variable, the delivery of spiritual care as the dependent variable, and demographic characteristics as grouping variables. This ensured that the statistical analyses were theory-driven and directly addressed the research questions and hypotheses, providing meaningful interpretations of differences and relationships in accordance with the framework.

These statistical methods were selected given the ordinal nature of Likert-scale data and the results of assumption testing, ensuring alignment between the data characteristics and the analytical techniques. Prior to conducting inferential analyses, statistical assumptions were rigorously evaluated to ensure the results were valid. Normality was assessed using the Shapiro-Wilk test, along with examination of skewness and kurtosis values. Results indicated significant deviations from normal distribution ($p < .05$), confirming that the data did not meet parametric assumptions. Outliers were examined using boxplots, and no extreme outliers were identified that could significantly distort the results. Given these findings, non-parametric statistical tests (Mann-Whitney U, Kruskal-Wallis H, and Spearman's Rho) were selected, as they do not assume normality and are appropriate for ordinal data derived from Likert scales.

Overall, the combination of descriptive and inferential statistical methods provided a robust analytical approach, allowing the study to summarize the data while also examining differences and relationships in a meaningful, theory-driven manner. These procedures ensured that the statistical techniques applied were methodologically appropriate and that the findings were valid, reliable, and interpretable within the study context.

Ethical Considerations

Ethical principles were strictly observed throughout the study. Permission was obtained from the respective hospital authorities prior to data collection. Participants were fully informed about the purpose, procedures, and potential benefits of the study, and informed consent was secured before participation. Participation in the study was strictly voluntary. To minimize potential coercion or undue influence, especially from authority figures such as hospital administrators or supervisors, recruitment was conducted independently, and no supervisors were directly involved in inviting participants. Respondents were clearly informed that their decision to participate or decline would not affect their employment status, professional evaluation, or relationship with their institution.

Participants were also assured that they could withdraw from the study at any time without any negative consequences. Confidentiality and anonymity were maintained by ensuring that no identifying information was disclosed, and all data were handled in accordance with the Data Privacy Act of 2012 (RA 10173). Data will be securely stored for 5 years and will be accessible only to the researchers. All electronic data are password-protected, and printed materials are kept in locked storage. After the retention period, all data will be permanently deleted. The dignity, beliefs, and well-being of all participants were respected throughout the research process.

Results and Discussion

Demographic Profile

Age

Table 1. *Demographic Profile of the Respondents
According to Their Age*

Age Bracket	Frequency	Percentage (%)
20 - 25	40	17.6
26 - 30	18	7.9
31 - 35	62	27.3
36 - 40	62	27.3
41 - 45	23	10.1
50 and above	22	9.7
Total	227	100

Table 1 presents the distribution of respondents according to age. The largest groups fall within the 31–35 and 36–40 age brackets, with 62 respondents (27.3%) each. Moreover, the 20–25 age group includes 40 respondents (17.6%). The 41–45 age group accounts for 23 respondents (10.1%), while those aged 50 and above comprise 22 respondents (9.7%). Lastly, the smallest proportion of respondents belongs to the 26–30 age bracket, with 18 respondents (7.9%). Overall, the data indicate that most respondents are in early to mid-adulthood.

The predominance of respondents in early to mid-adulthood suggests that the nursing workforce in this study is largely composed of individuals in active stages of professional and personal development. At this stage, nurses are more likely to be refining their clinical competencies, strengthening their professional identity, and integrating personal values into practice. From a theoretical perspective, this finding can be explained using the Process–Person–Context–Time (PPCT) Model by Bronfenbrenner (1994). In this model, age represents the “Person” component, which influences how individuals develop beliefs, values, and behaviors over time. As nurses progress through adulthood, their spiritual understanding may become more stable and integrated into both personal and professional domains. This is supported by Gale et al. (2023), who emphasized that spiritual development evolves across the lifespan and is shaped by accumulated experiences and life stages. Thus, examining age provides insight into how nurses’ spiritual perceptions may differ and develop over time.

Sex

Table 2. *Demographic Profile of the Respondents
According to Their Sex*

Sex	Frequency	Percentage (%)
Female	177	78.0
Male	50	22.0
Total	227	100

Table 2 presents the distribution of respondents according to sex. The majority of respondents are female, comprising 177 individuals (78.0%). In contrast, male respondents account for 50 individuals (22.0%). Overall, the data show that females represent a significantly larger proportion of the sample. The predominance of female respondents reflects the traditional gender distribution in the nursing profession, where caregiving roles have historically been associated with women. This pattern suggests that sociocultural expectations continue to influence career choices and workforce composition in nursing.

From a theoretical perspective, this finding can be explained using Kolcaba’s Theory of Comfort (Kolcaba, 1994), which emphasizes the importance of empathy, interpersonal connection, and holistic care in nursing practice. These qualities, often nurtured socially across genders, contribute to the delivery of psychospiritual comfort to patients. However, it is important to note that while sex may influence how care is expressed, it does not determine an individual’s level of spirituality or ability to provide spiritual care. Instead, spiritual care is shaped by personal values, professional training, and clinical experience. This finding is consistent with the World Health Organization (2020), which reports that the nursing workforce remains predominantly female despite increasing efforts to encourage gender diversity. The continued underrepresentation of males may be influenced by societal perceptions and gender-role expectations associated with caregiving professions.

Religion

Table 3. Demographic Profile of the Respondents According to Their Religion

Religion	Frequency	Percentage (%)
Roman Catholic	186	81.9
Seventh-day Adventist	3	1.3
Iglesia ni Cristo	12	5.3
Aglipayan	2	0.9
Born Again Christian	20	8.8
Bible Baptist	1	0.4
Others	3	1.3
Total	227	100

Table 3 presents the distribution of respondents according to religion. The majority are Roman Catholic, with 186 respondents (81.9%). This is followed by Born Again Christians, with 20 respondents (8.8%), and Iglesia ni Cristo, with 12 respondents (5.3%). Seventh-day Adventists and other religions each have 3 respondents (1.3%). The Aglipayan group includes 2 respondents (0.9%), while Bible Baptist has the smallest representation with 1 respondent (0.4%). Overall, the data indicate that most respondents are Roman Catholic.

The predominance of Roman Catholic respondents reflects the broader religious landscape of the Philippines, where Catholicism plays a significant role in shaping cultural values and belief systems. This suggests that shared cultural and religious traditions may influence nurses' spiritual perspectives. From a theoretical perspective, this finding can be explained using Puchalski's Spirituality and Health Model (Puchalski, 2001), which emphasizes that spirituality extends beyond religious affiliation to include meaning, purpose, and connectedness. While religion may serve as a foundation for spiritual beliefs, spiritual care in nursing remains patient-centered and is not limited to the caregiver's personal faith.

Despite differences in religious affiliation, many belief systems promote common values such as compassion, empathy, and respect. These shared principles support holistic nursing care and reinforce the idea that spirituality serves as a unifying dimension in clinical practice. This finding is supported by Balay-Odao et al. (2024) and Murgia et al. (2020), who highlighted that spirituality enhances compassionate care and supports patients' emotional and spiritual well-being. These studies suggest that faith and spiritual awareness can positively influence nurses' approach to patient care. Furthermore, in line with Leininger's Transcultural Nursing Theory, nurses are expected to provide culturally congruent care by respecting and integrating patients' diverse spiritual and religious beliefs. This reinforces the importance of viewing spirituality not only as a personal attribute but also as a professional responsibility in delivering holistic care.

Type of School Graduated

Table 4. Demographic Profile of the Respondents According to Their Type of School Graduated

Type of School Graduated	Frequency	Percentage (%)
Sectarian School	119	52.4
Non-Sectarian School	108	47.6
Total	227	100

Table 4 presents the distribution of respondents according to the type of school they graduated from. A slight majority of respondents graduated from sectarian schools, with 119 respondents (52.4%). Meanwhile, 108 respondents (47.6%) graduated from non-sectarian schools. Overall, the data show that both sectarian and non-sectarian educational backgrounds are almost equally represented among the respondents.

The minimal difference between respondents from sectarian and non-sectarian institutions suggests that the nursing workforce in this study comprises individuals with diverse educational backgrounds. This indicates that exposure to values related to spirituality may occur across different types of educational settings. From a theoretical perspective, this finding can be explained using Leininger's Transcultural Nursing Theory, which emphasizes that individuals develop their beliefs, values, and practices through various cultural and social influences, including education. Both sectarian and non-sectarian institutions help shape students' worldviews,

which may later influence their perceptions of spirituality and their approach to patient care.

In addition, Puchalski's Spirituality and Health Model (Puchalski, 2001) highlights that spirituality is a multidimensional construct that is not solely dependent on formal religious instruction. Instead, it develops through personal experiences, interpersonal relationships, and professional exposure. This suggests that regardless of the type of institution attended, nurses may still develop a strong sense of spirituality that can be integrated into clinical practice. Non-sectarian schools typically provide a general educational environment without specific religious affiliation, while sectarian schools often incorporate faith-based values and moral development into their curriculum (Main Line Parent, 2023). Despite these differences, both types of institutions can contribute to the formation of ethical values, empathy, and a sense of purpose among students. Thus, the findings suggest that educational background, whether sectarian or non-sectarian, does not limit the development of spirituality. Instead, spirituality in nursing is shaped by a combination of educational experiences, cultural influences, and personal beliefs.

Years in Nursing Practice

Table 5. *Demographic Profile of the Respondents According to Their Years in Nursing Practice*

Years	Frequency	Percentage (%)
0 - 5 years	90	39.6
6 - 10 years	45	19.8
11 - 15 years	36	15.9
15 - 20 years	32	14.1
>20 years	24	10.6
Total	227	100

Table 5 presents the distribution of respondents by years of nursing practice. The largest group consists of nurses with 0–5 years of experience, totaling 90 respondents (39.6%). This is followed by those with 6–10 years of experience, with 45 respondents (19.8%). Nurses with 11–15 years of experience account for 36 respondents (15.9%), while those with 15–20 years comprise 32 respondents (14.1%). Lastly, the smallest group consists of nurses with more than 20 years of experience, with 24 respondents (10.6%). Overall, the data indicate that the majority of respondents are early-career nurses.

The predominance of early-career nurses suggests that the nursing workforce in this study is largely composed of individuals who are still in the process of strengthening their professional identity and clinical competence. This distribution may reflect the continuous influx of newly licensed nurses entering healthcare settings to meet workforce demands. From a theoretical perspective, this finding can be explained using Puchalski's Spirituality and Health Model (Puchalski, 2001), which emphasizes that spirituality serves as an internal resource that provides meaning, purpose, and coping regardless of professional experience. This suggests that even nurses in the early stages of practice may already possess a well-developed sense of spirituality that influences their approach to patient care.

In addition, Kolcaba's Theory of Comfort (Kolcaba, 1994) supports the idea that the ability to provide holistic care, including psychospiritual support, is not solely dependent on years of experience but on the nurse's awareness of patients' multidimensional needs. Both novice and experienced nurses can therefore contribute meaningfully to patients' comfort and well-being. The distribution of respondents also reflects the ongoing entry of new nurses into the workforce, which may be associated with healthcare expansion and staffing needs. However, no causal inference is made regarding workforce retention or turnover, as the data only describe the demographic composition of the sample. As supported by Guo et al. (2023), spirituality is an intrinsic component of nursing practice that helps nurses find meaning in their work and enhances their ability to cope with professional challenges. This reinforces the idea that spirituality is not determined by length of experience but is consistently present across all stages of nursing practice.

Area of Practice

Table 6 presents the distribution of respondents by area of practice. The Emergency Room has the highest number of respondents with 51 (22.5%). This is followed by Hemodialysis, with 32 respondents (14.1%), and the Operating Room, with 31 respondents (13.7%). The Medical-Surgical Ward has 22 respondents (9.7%), while the Pediatric

Ward has 20 respondents (8.8%). Both the Intensive Care Unit and Neonatal Intensive Care Unit have 15 respondents each (6.6%). The Obstetrics-Gynecology Ward has 14 respondents (6.2%), while “Others” account for 13 respondents (5.7%). The Delivery Room has 8 respondents (3.5%), and the Infectious Disease Ward has the lowest number with 6 respondents (2.6%). Overall, respondents are distributed across various clinical areas, with the Emergency Room having the highest representation.

Table 6. *Demographic Profile of the Respondents According to Their Area of Practice*

Areas	Frequency	Percentage (%)
Medical-Surgical Ward	22	9.7
Pediatric Ward	20	8.8
Obstetrics-Gynecology Ward	14	6.2
Emergency Room	51	22.5
Intensive Care Unit	15	6.6
Infectious Disease Ward	6	2.6
Neonatal Intensive Care Unit	15	6.6
Operating Room	31	13.7
Delivery Room	8	3.5
Hemodialysis	32	14.1
Others	13	5.7
Total	227	100

The distribution of respondents across different clinical areas indicates exposure to a wide range of healthcare settings, each with varying levels of patient acuity, workload, and care demands. The higher proportion of respondents in the Emergency Room reflects its role as a critical entry point for acute and urgent care services. From a theoretical perspective, Kolcaba’s Theory of Comfort (Kolcaba, 1994) explains that, regardless of clinical setting, nurses are expected to address patients’ physical, psychospiritual, environmental, and sociocultural needs. In high-acuity environments such as the Emergency Room, this requires nurses to provide not only immediate physical interventions but also emotional and spiritual support within time-sensitive situations. Similarly, Puchalski’s Spirituality and Health Model (Puchalski, 2001) emphasizes that spiritual care remains an essential component of holistic nursing practice, even in fast-paced and technologically driven environments. Nurses may express spiritual care through presence, active listening, reassurance, and compassionate communication.

The higher number of respondents in the Emergency Room may reflect the distribution of nurses across hospital units or the accessibility and willingness of nurses in that area to participate in the study. However, no assumption is made regarding workload demand or staffing adequacy, as the data only reflect sample distribution and not institutional staffing ratios. As supported by McSherry et al. (2020), nurses working in emergency settings continue to provide spiritual care despite high workload demands, often through simple but meaningful interventions such as presence, touch, and active listening. This highlights that spiritual care remains integral even in fast-paced clinical environments. Thus, the findings suggest that spiritual care is consistently integrated across different areas of practice, reinforcing its role as a universal component of holistic nursing care rather than being dependent on specific clinical settings.

Level of Spirituality

Table 7 presents the respondents’ level of spirituality across different indicators. The overall mean score is 3.36 ($SD = 0.479$), interpreted as Very High. The highest-rated indicator is “My relationship with God helps me cope with challenges in my personal and professional life” ($M = 3.57$). This is followed by items indicating that spirituality is an important aspect of well-being ($M = 3.44$) and that it extends beyond religious beliefs to encompass personal values and life meaning ($M = 3.41$). Similarly, alignment of spirituality with ethical and moral values also obtained a high rating ($M = 3.41$). Other indicators, such as finding meaning through religious practices ($M = 3.33$), perceiving spirituality as essential to human existence ($M = 3.37$), and having a sense of purpose through spiritual practices ($M = 3.38$), were also rated very high. Meanwhile, lower – but still high – ratings were observed in job satisfaction connected to spirituality ($M = 3.18$), willingness to discuss spirituality with others ($M = 3.23$), and how spirituality influences interactions with others ($M = 3.24$). Overall, the findings indicate a consistently high level of perceived spirituality among nurses.

Table 7. Respondents' Level of Perceived Spirituality

	Mean	SD	Remarks
Spirituality encompasses more than just religious beliefs; it includes personal values and life meaning.	3.41	0.620	Very High
Having connected to a higher power allows me to experience job satisfaction.	3.18	0.775	High
My spirituality aligns with my ethical and moral values in decision-making.	3.41	0.598	Very High
My relationship with God helps me cope with challenges in my personal and professional life.	3.57	0.586	Very High
My personal spirituality influences how I interact with others.	3.24	0.637	High
I find meaning and hope through attending religious services, praying daily, and reflecting on my faith during challenging times.	3.33	0.590	Very High
I feel that my life has a greater purpose or meaning when I engage in spiritual practices.	3.38	0.601	Very High
I believe spirituality is an important aspect of my overall well-being.	3.44	0.623	Very High
I am comfortable discussing my own spirituality with others.	3.23	0.626	High
I consider spirituality a distinct and essential aspect of human existence.	3.37	0.583	Very High
Means	3.36	0.479	Very High

Legend: 1.00-1.75 – Strongly Disagree (Low); 1.76-2.50 – Disagree (Moderate); 2.51-3.25 – Agree (High); 3.26-4.00 – Strongly Agree (Very High)

The very high level of spirituality among respondents suggests that spirituality is a deeply embedded component of nurses' personal belief system and professional identity. This indicates that nurses perceive spirituality not only as a religious construct but also as a source of meaning, coping, and ethical guidance in both personal and clinical contexts. From a theoretical perspective, this finding is strongly supported by Puchalski's Spirituality and Health Model (Puchalski, 2001), which explains that spirituality provides individuals with meaning, purpose, and connectedness. The high ratings in coping, values alignment, and sense of purpose reflect spirituality's role as an internal resource that supports resilience and well-being.

In addition, Leininger's Transcultural Nursing Theory (Leininger, 2002) emphasizes that cultural and personal beliefs shape how individuals understand and express care. In this context, nurses' spirituality forms part of their worldview, influencing how they interpret experiences and engage with patients. Kolcaba's Theory of Comfort (Kolcaba, 1994) further supports this finding by highlighting psychospiritual comfort as a key dimension of holistic care. Nurses who report high levels of spirituality are more likely to experience meaning in their work and demonstrate caring behaviors that support patient comfort and well-being.

The slightly lower scores in communication of spirituality and its influence on interpersonal interactions may suggest that while nurses possess strong internal spirituality, they may be less expressive or less comfortable verbalizing it in professional settings. This reflects the distinction between internal spiritual belief and external expression in clinical practice. Overall, the findings emphasize that spirituality among nurses extends beyond religious practice to meaning-making, ethical grounding, and coping, all of which contribute to holistic nursing care.

Level of Spiritual Care

Table 8. Respondents' Level of Perceived Spiritual Care

	Mean	SD	Remarks
I offer prayer for my patients, or I pray with them when requested.	3.13	0.834	High
I encourage patients to express their spiritual concerns.	3.16	0.799	High
I respect patients' wishes/requests for a quiet and peaceful environment.	3.65	0.547	Very High
I help patients explore and understand the personal significance of their illness, guiding them to find strength, resilience, and purpose in their healing journey.	3.38	0.702	Very High
I use therapeutic touch, like tapping my patient's shoulder, to convey a sense of presence and comfort.	3.47	0.680	Very High
I provide comforting words and reassurance that align with the patient's beliefs.	3.47	0.604	Very High
I offer spiritual resources such as calming music.	2.86	0.924	High
I respect and accommodate cultural and religious practices related to healing and end-of-life care.	3.48	0.612	Very High
I actively listen to my patients without judgment, allowing them to share their spiritual struggles.	3.55	0.611	Very High
I encourage the patient's family to be present and offer emotional support through touch, presence, or kind words.	3.49	0.612	Very High
Mean SC	3.36	0.455	Very High

Legend: 1.00-1.75 – Never (Low); 1.76-2.50 – Seldom (Moderate); 2.51-3.25 – Sometimes (High); 3.26-4.00 – Always (Very High)

Table 8 presents the respondents' level of spiritual care across different indicators. The overall mean score is 3.36 ($SD = 0.455$), interpreted as Very High, indicating that nurses consistently integrate spiritual care into their practice. The highest-rated indicators include respecting patients' wishes for a peaceful environment ($M = 3.65$), actively listening without judgment ($M = 3.55$), encouraging family presence and support ($M = 3.49$), and respecting cultural and religious practices related to care ($M = 3.48$). Similarly, providing comfort through therapeutic touch and offering reassuring words aligned with patients' beliefs both obtained high mean scores ($M = 3.47$). Other indicators, such as helping patients explore meaning in illness ($M = 3.38$) and encouraging expression of spiritual concerns ($M = 3.16$), were also rated high to very high. Lower – but still positive – ratings were observed in offering prayer when requested ($M = 3.13$) and providing spiritual resources such as calming music ($M = 2.86$), though both remain within the high category. Overall, the results indicate that nurses frequently demonstrate spiritual care behaviors in clinical practice.

The very high level of spiritual care indicates that nurses actively integrate spiritual support into patient care, particularly through presence, communication, respect for beliefs, and creation of a healing environment. This suggests that spiritual care is not treated as a separate task but as an integral part of holistic nursing practice. From a theoretical perspective, Kolcaba's Theory of Comfort (Kolcaba, 1994) explains these findings by emphasizing that nursing care must address physical, psychospiritual, environmental, and sociocultural comfort. The high ratings in active listening, therapeutic touch, and environmental comfort reflect nurses' efforts to provide psychospiritual relief to patients. Similarly, Puchalski's Spirituality and Health Model (Puchalski, 2001) supports the idea that spiritual care is an extension of the nurse's own sense of meaning and connectedness. Nurses who are spiritually aware are more likely to respond to patients' emotional and spiritual needs through compassionate presence and supportive communication. The findings also suggest that spiritual care is most commonly expressed through relational and non-verbal interventions, such as listening, presence, and emotional reassurance, rather than explicitly religious practices such as prayer or spiritual resources. This reflects a broader, more inclusive understanding of spirituality in nursing practice.

The lower mean score in providing structured spiritual resources (e.g., calming music) may indicate limited availability of resources or situational constraints in clinical settings rather than a lack of willingness to provide care. Overall, the results demonstrate that spiritual care is consistently practiced across respondents, reinforcing its role as a fundamental component of holistic nursing care.

Test of Difference

Table 9. Results of the Test of Difference in Spirituality and Spiritual Care When Grouped According to Age, Sex, Religion, Type of School Graduated, Years in Nursing Practice, and Area of Practice

Variable	Aspect	p-value	Remarks
Age	Spirituality	.892	Not Significant
	Spiritual Care	.164	Not Significant
Sex	Spirituality	.886	Not Significant
	Spiritual Care	.026	Significant
Religion	Spirituality	.494	Not Significant
	Spiritual Care	.763	Not Significant
Type of School Graduated	Spirituality	.487	Not Significant
	Spiritual Care	.723	Not Significant
Years in Nursing Practice	Spirituality	.084	Not Significant
	Spiritual Care	.454	Not Significant
Area of Practice	Spirituality	.079	Not Significant
	Spiritual Care	.252	Not Significant

Table 9 presents a summary of the differences in nurses' perceptions of spirituality and spiritual care, grouped by selected demographic variables, including age, sex, religion, type of school graduated from, years in nursing practice, and area of practice. The results indicate that age does not significantly influence nurses' perceptions of spirituality ($p = .892$) or spiritual care ($p = .164$). This suggests that spiritual awareness and the delivery of spiritual care are consistently maintained across developmental stages. From a theoretical perspective, this supports holistic nursing frameworks, which posit that spirituality is a fundamental and universal dimension of care embedded within professional nursing values rather than dependent on age or experience. Consistent with Baysal et al. (2024), both younger and older nurses appear equally capable of integrating spirituality into clinical practice.

Regarding sex, no significant differences were observed in spirituality ($p = .886$), but a statistically significant difference emerged in spiritual care ($p = .026$). This indicates that while personal spirituality is similar across genders, slight variations may exist in the expression of spiritual care behaviors. From a theoretical standpoint, this aligns with Kolcaba's Theory of Comfort, suggesting that differences in interpersonal communication and emotional responsiveness—often socially influenced—may account for variations in psychospiritual comfort provided to patients.

For religion, no significant differences were found in spirituality ($p = .494$) or spiritual care ($p = .763$), indicating that nurses deliver spiritual care consistently regardless of personal religious affiliation. This aligns with Puchalski's Spirituality and Health Model, which emphasizes that spiritual care should be patient-centered and guided by patients' needs rather than the caregiver's personal beliefs. Universal values such as compassion, empathy, and respect underpin spiritual care practices across diverse belief systems.

Similarly, the type of school graduated from did not produce significant differences in spirituality ($p = .487$) or spiritual care ($p = .723$), suggesting that formal educational background alone is not a primary determinant of spiritual perceptions or practices. Instead, spirituality appears to develop through a combination of personal beliefs, clinical exposure, and experiential learning, consistent with Leininger's Transcultural Nursing Theory, which highlights the influence of cultural and personal experiences in shaping care behaviors.

Years in nursing practice also did not significantly affect spirituality ($p = .084$) or spiritual care ($p = .454$), indicating that both novice and experienced nurses maintain comparable perceptions and practices. This supports the theoretical proposition that spirituality is an intrinsic component of nursing identity rather than a skill acquired solely through experience. Nurses' internalized values and personal meaning serve as guiding principles throughout their careers, reinforcing holistic care practices (Guo et al., 2023).

Finally, the area of practice did not show significant differences in spirituality ($p = .079$) or spiritual care ($p = .252$), suggesting that the integration of spiritual care is consistent across clinical settings. This supports the universality of spiritual care as emphasized in holistic nursing theory, which posits that attending to patients' spiritual needs is essential regardless of the unit or clinical context (Baguna et al., 2024).

Overall, the findings indicate that most demographic variables do not significantly influence nurses' perceptions of spirituality and spiritual care. This underscores the theoretical assumption that spirituality functions as a core, universal, and intrinsic component of nursing practice, guided more by shared professional values and internal belief systems than by external demographic factors. The only exception is sex, which shows a statistically significant but practically minimal difference in the delivery of spiritual care. These results reinforce the study's conceptual framework, demonstrating that nurses' internal perceptions of spirituality are consistently translated into patient-centered care, supporting the integration of holistic and spiritually responsive practices across diverse healthcare contexts.

Correlation Analysis

Table 10. *Results of the Test of the Correlation Between Spirituality and Spiritual Care*

Spirituality	Spiritual Care	
	Spearman's rho	0.431
	df	225
	p-value	< .001

Table 10 presents the results of Spearman's rho correlation analysis examining the relationship between nurses' spirituality and spiritual care. The analysis revealed a statistically significant moderate positive correlation between spirituality and spiritual care ($\rho = .431$, $df = 225$, $p < .001$). This indicates that higher levels of spirituality are associated with higher levels of engagement in spiritual care among nurses. The result is statistically significant, suggesting that the observed relationship is unlikely to have occurred by chance.

The findings indicate a moderate positive relationship between nurses' spirituality and their provision of spiritual care. This suggests that nurses who report higher levels of personal spirituality are more likely to engage in behaviors that support patients' spiritual needs.

From a theoretical perspective, this finding is supported by Puchalski's Spirituality and Health Model (Puchalski, 2001), which posits that spirituality provides meaning, purpose, and connectedness that influence how healthcare providers respond to patients' holistic needs. In this context, spirituality functions as an internal resource that guides nurses in recognizing and addressing spiritual concerns in clinical practice.

Kolcaba's Theory of Comfort (Kolcaba, 1994) further supports this result by emphasizing that psychospiritual comfort is a core dimension of holistic care. Nurses with stronger spiritual awareness are more likely to deliver interventions that enhance emotional and spiritual well-being, contributing to overall patient comfort. Additionally, Leininger's Transcultural Nursing Theory (Leininger, 2002) explains that personal values and beliefs influence caregiving behaviors. Nurses' spirituality may therefore shape how they interpret patients' needs and deliver culturally and spiritually sensitive care. It is important to emphasize that Spearman's rho measures the strength and direction of association between variables and does not establish causation. Therefore, the results indicate a relationship between spirituality and spiritual care, but do not imply that one variable causes or predicts the other. These findings are consistent with Baguna et al. (2024), who also reported a significant positive relationship between nurses' spirituality and their engagement in spiritual care practices. This convergence strengthens the evidence that spirituality is meaningfully associated with the integration of spiritual care in nursing practice.

Conclusion

In conclusion, this study provides empirical and theoretical support for the significant association between nurses' perceptions of spirituality and their delivery of spiritual care. This reinforces the understanding that spirituality is not merely a personal belief system but an essential dimension of professional nursing practice, contributing to holistic and patient-centered care.

The findings further demonstrate that most demographic variables do not significantly influence nurses' perceptions of spirituality and spiritual care, suggesting that these constructs are generally embedded within the shared values and ethical foundations of the nursing profession. This highlights spirituality as a universal component of nursing practice rather than one dependent on personal or demographic characteristics.

Notably, a statistically significant difference in the delivery of spiritual care was found by sex, although the small effect size indicates a limited practical difference. This finding suggests that while both male and female nurses provide spiritual care, there may be subtle variations in how it is expressed in practice, potentially influenced by communication style or emotional expression rather than differences in spiritual orientation. This highlights the importance of ensuring that spiritual care training in nursing education is inclusive and sensitive to variations in caregiving expression across genders.

This study contributes to nursing knowledge by providing localized, theory-based evidence from healthcare settings in San Pablo City, Laguna, demonstrating how nurses' internal spirituality translates into clinical practice. By integrating empirical findings with established theoretical frameworks, this research strengthens the understanding of spirituality as both a personal and professional construct in nursing care.

From a practical perspective, the findings underscore the need to further integrate spirituality into nursing education, clinical training, and institutional policies. Nursing curricula should strengthen competencies in spiritual assessment and care delivery, while healthcare institutions should promote supportive environments that encourage the consistent practice of holistic care. Enhancing nurses' spiritual awareness and skills may improve their confidence in addressing patients' spiritual needs and contribute to more compassionate care delivery.

This study is limited by the use of purposive sampling and its focus on selected institutions, which may affect generalizability. Additionally, the reliance on self-reported data may introduce response bias. Future research may consider larger and more diverse populations and utilize mixed-method approaches to gain deeper insight into the role of spirituality in nursing practice.

Overall, the study emphasizes that strengthening nurses' spirituality is essential to promoting holistic care. Supporting nurses through education, training, and organizational initiatives can enhance their ability to address

the spiritual dimension of patient care, ultimately improving patient well-being and the quality of nursing practice.

Contributions of Authors

Author 1: abstract, introduction, data gathering, literature review, results & discussion, conclusion

Author 2: research design, research instrument, literature review, results & discussion

Author 3: participants & sampling technique, ethical considerations, literature review, results & discussion

Author 4: data analysis procedure, literature review, results & discussion

Author 5: academic mentoring, research supervision, methodological consultation, manuscript review

Author 6: supervision, methodological guidance, refinement of the conceptual framework, manuscript review

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