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Workplace Spiritual Climate and Its Influence on Nurses' Provision of Spiritual Care in Multicultural Hospitals

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Abstract: Background: Spiritual care is a growing field of interest in the healthcare industry in Saudi Arabia, one that is largely defined by the religious and cultural context of the country that has a rich and strong backdrop. Workplace spiritual climate may have a significant impact on nurses' ability and willingness to provide spiritual care. This study aims to examine the influence of workplace spiritual climate on nurses' provision of spiritual care. Methods: A convenience sample of 918 nurses employed in seven public hospitals in Saudi Arabia was surveyed in this cross-sectional study using the Spiritual Climate Scale (SCS) and the Spiritual Care Intervention-Provision Scale (SCIPS). Results: The overall mean in the SCS was 64.58 (SD = 24.60), whereas the overall mean in the SCIPS was 56.83 (SD = 9.46). Nurses with Saudi nationality, with Islamic faith, with administrative functions, and with higher years of experience as a nurse reported better perceptions of workplace spirituality. Hospital, position, years of experience in the present hospital, and the hospital's spiritual climate were identified as significant predictors of the nurses' spiritual care interventions provision. Conclusions: The results of the study support the importance of having good workplace spiritual climate as it impacts the nurses' provision of spiritual care interventions.

Keywords: Saudi Arabia; spirituality; spiritual care; spiritual care interventions; spiritual climate; workplace spirituality

1. Introduction

In recent years, workplace spiritual climate has had a significant impact on nurses' abilities and willingness to provide spiritual healthcare (Hassan et al. 2016). The same may have a positive correlation with nurses' provision of spiritual care, especially in the context of Arab countries (Musa and Pevalin 2016). In some circumstances though, the provision of spiritual care may otherwise be affected because of the lack of a shared spiritual language and other factors (Alosaimi 2013). Therefore, nurses' provision of spiritual care must be investigated. This topic is worth investigating because it may enable hospital and spiritual caregivers to understand and incorporate these factors and the findings in this research into policies and practices for enhanced spiritual healthcare provision. A

recent research reported that shared spiritual values enable the caregiver and patient to give a new dimension to spiritual care (Khari and Sinha 2017).

Spirituality is defined as a "dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence and experience relationship to self, family, others, community, society, nature, and the significant or sacred" (Hall et al. 2016, p. 4). Spirituality is multifaceted and could be expressed through beliefs, values, traditions, and practices (Hall et al. 2016). It allows individuals within a society to connect and relate to one other on various levels and achieve harmony and peace (Afsar and Rehman 2015). Religion is one of the many ways in which individuals express their spirituality. However, other people connect spiritually through other means such as in relationships, in nature, or in a set of beliefs (Hall et al. 2016). Reinert and Koenig (2013) proposed that spirituality in the nursing profession is outlined within the spiritual involvement context. They subscribed to the definition of Koenig et al. (2012, p. 46) that "spirituality is distinguished from other things—humanism, values, morals, and mental health—by its connection to the transcendent." The workplace spirituality climate is an entirely different concept that is usually seen in the abovementioned context. It is widely established that "the recognition that employees have an inner life that nourishes and is nourished by meaningful work that takes place in the context of community" (Ashmos and Duchon 2000, p. 137). According to this idea, workplace spirituality is composed of three elements, particularly inner self, meaningful work, and its society (Ashmos and Duchon 2000). Workplace spirituality helps individuals involved in an organisational process to build trust and cooperation. This understanding, in turn, results in better performance and helps achieve better results. Therefore, spirituality at the workplace is a new arena for businesses and corporations to enhance their employees' performance (Hassan et al. 2016). Spiritual care, in contrast, is a self-generated, social, selfless, and combined assertion in relation to nurses' transcendent awareness towards their personal lives (Sawatzky and Pesut 2005). Most clinicians, including nurses, often combine the concepts of spirituality and religion. However, as stated earlier, people have different ways of expressing spirituality, and this should be taken into consideration by nurses when providing spiritual care (Hughes et al. 2017).

Workplace spirituality is often divided into two components: the religious aspect, which is focused on religious beliefs, a connection with a higher Being, and religious practices, and the existential aspect, which is centred in the relationship with the self and others (Musa and Pevalin 2016). This spirituality-based care not only has a positive impact on nurses' provision of care in general but also has a significant positive correlation with their sense of meaningfulness and relationship with their patients (Musa and Pevalin 2016).

Growing evidence supports that spirituality has a positive and direct relationship with the provision of healthcare services (Cruz et al. 2017b; Hall et al. 2016). This is a complicated concept, and to implement it effectively, a wider understanding of spirituality concept and spiritual care is required (Rogers and Wattis 2015). Towards this objective, it is relevant to acknowledge recent findings suggesting that workplace spirituality is not based on a random outcome but on one that can be managed and directed on a healthcare-setting level. A previous study suggests a very strong correlation between the workplace spiritual climate and various factors contributing towards the success of a healthcare setting, more specifically on nurses' dedication, motivation, and provision of services. A past study argues that spirituality in the workplace towards spiritual care provision has a strong religious aspect, which has an exponential effect on the effectiveness and viability of spiritual caregiving (Affeldt and MacDonald 2010). Thus, it may be incorporated in the same in an individual nurse's level by promoting it as a cultural norm by effective management (Pirkola et al. 2016).

The subject of spirituality and healthcare has roots in ancient Islamic views. However, its recent implications have origins in Christianity as it stems from Western nations. Although both seem the same, the difference in the underlying concepts that guide the relationship between spirituality and healthcare is significant. In the context of Arab Muslim countries, the spiritual aspect of healthcare is very significant with its physical counterpart as the former is deemed to affect the latter (Lovering 2012).

Spirituality in the Saudi Arabian context has its roots in religious and cultural values. Meanwhile, nurses must incorporate religious and cultural values as integral parts of their care (Lovering 2008). In the same vein, it may also be argued that the spiritual healthcare climate in Saudi Arabia has been largely formed on values that are integral to an Arab society, for example, family orientation and Islam. The same has been found to be true in the case of other Arab countries (Atkinson 2015). Furthermore, the practice of spiritual coping techniques has been found to be effective on nurses' and patients' end almost equally. Recent studies conducted on patients and their caregivers in Saudi Arabia suggest that its relevance grows with age and variety of other socioeconomic factors on both ends (Cruz et al. 2017a; Cruz et al. 2016a; Cruz et al. 2016c).

Spiritual care is a growing field of interest in the healthcare industry in Saudi Arabia (Cruz et al. 2017a, 2017b), one that is largely defined by the religious and cultural context of the country that has a rich and strong backdrop. People's life in the country is heavily influenced by their Islamic faith. Hence, the religious dimension of spiritual care is critical in the achievement of holistic care among Saudi patients (Alshehry 2018). For instance, in a study conducted by Cruz et al. (2017a) among Saudi patients receiving hemodialysis treatment, the respondents reported a high degree of religiosity. Performing religious activities, such as praying in private (Nawafl), doing the obligatory prayers (Fard), reading and reciting the Holy Qur'an, and watching or listening to religious programs, had a positive impact on their health-related quality of life. This finding is also supported by the Crescent of Care nursing model, which emphasized the importance of a holistic approach in caring for Saudi patients. The model demonstrated the intertwining of caring and the faith of Saudi patients, which is Islam. In order to achieve full satisfaction of a Saudi patient, a caregiver should attend to the patient's spiritual, cultural, psychosocial, and clinical needs (Lovering 2008, 2012). Spiritual care in this model is defined as nursing interventions that address the spiritual needs of both patient and their family (Lovering 2012).

Nurses from different countries and belief systems face challenges in understanding, coping with, and managing spiritual climate in healthcare settings. However, in Saudi Arabia and other Arab countries, nurses with a similar disposition towards spirituality, workplace spirituality, and spiritual care have reported positive implications of spiritual healthcare on their performance and work quality. Spiritual care in Saudi Arabia must be viewed as having the same religious grounds; otherwise, it will largely seem independent of these values. These factors might likely affect how nurses understand the spiritual climate and how they deliver spiritual care to patients in Saudi.

The objective of the present research is to evaluate the workplace spiritual climate and its influence on nurses' provision of spiritual care in seven hospitals in Saudi Arabia. This research objective and the relationship between the workplace spiritual climate, the religious role in spiritual care, and its effect on nurses' provision of spiritual care may enable the incorporation of new dimensions to it. It may be a step towards the resolution of one of the core issues around spiritual health care in Saudi Arabia and the Arab Muslim world (Cruz et al. 2016b).

2. Materials and Methods

This descriptive, cross-sectional study was conducted in seven government hospitals in Saudi Arabia. Five of the seven hospitals (Hospitals A, D, E, F, and G) are in the central region, whilst the remaining two (Hospitals B and C) are situated in the Northern region. Hospital A has a 500-bed capacity, whilst Hospitals B and C have 280- and 250-bed capacities, respectively. Hospital D has a 225-bed capacity, Hospital E has a 200-bed capacity, and Hospitals F and G have the same 150-bed capacity. A total of 2101 nurses were presently employed in the seven hospitals during the study. Using the Survey Monkey®sample size calculator (https://www.surveymonkey.com/mp/sample-size-calculator/), the required sample size at a 95% confidence level and a 5% margin of error was 325 nurses. Using the convenience sampling technique, 1200 surveys were distributed to ensure an adequate sample size. From the 1200 questionnaires, 931 were returned and 13 questionnaires were

omitted because of incomplete data. In the end, a total of 918 survey questionnaires were used in the final analysis (response rate = 76.5%).

The respondents' recruitment process was done by visiting nurses during their break time and inviting them to take part in this study. Nurses who occupy any position and who were employed in the hospital for a minimum of six months were invited to participate.

2.1. Data Collection

The researchers gathered data from May to August 2017. Prior to data gathering, the researchers coordinated with the hospital nursing administration to ask for a copy of the nurses' monthly schedule. The distribution of questionnaires was conducted to each respondent during their free time to avoid disrupting them at work. Instructions about the study objective were discussed to the respondents. If the respondents had queries about the questionnaire, the researchers expanded and discussed each query. The respondents were instructed not to write their name or anything that would identify them in the questionnaire. A blank white envelope was also distributed with the questionnaire. The respondents were told to put the questionnaire in the blank envelope after responding to it and to seal it themselves before returning it to the researchers. The sealed envelopes containing the questionnaires were collected the next day. All collected questionnaires were kept in a locked cabinet until the data collection period was over.

A three-section, self-administered survey questionnaire was used in gathering respondents' information. The first section consisted of questions about the respondents' demographics, including age, sex, nationality, marital status, religion, and highest educational level. Total years of experience as a nurse, in Saudi Arabia, and in their present hospital were also inquired. In addition, their position held at the present hospital and areas of practice were asked.

Part two was the Spiritual Climate Scale (SCS). The SCS assesses the perceptions of healthcare workers on the spiritual climate of their hospital. The scale has four items in a 5-point Likert scale. The scale scores are calculated by obtaining the average of the item scores, subtracting one, and then multiplying by 25. Scores can range from 0 to 100. The percentage reporting good spiritual climate was also calculated per item of the scale. A positive workplace spiritual climate is signified by high SCS scores, and a high percentage presents a good spiritual climate (Doram et al. 2017). The English SCS version was used in collecting information from the English-speaking nurses, whereas the Arabic version was used for Arabic-speaking respondents.

Part three consisted of the Spiritual Care Intervention-Provision Scale (SCIPS; Musa and Pevalin 2016). The scale measured the nurses' spiritual care intervention provision that reflects each religious and spirituality existential dimension. The scale has 17 items: eight of which are religious, whereas nine are existential. It is responded using a 4-point Likert scale (4 = "always" and 1= "never"). Scale scores can be obtained by adding the responses to all 17 items ranging from 17 to 68. A higher score suggests a better provision of spiritual care interventions (Musa and Pevalin 2016).

2.2. Validity and Reliability

The English and Arabic versions of the SCS were tested for validity and reliability in previous studies (Cruz et al. 2018; Doram et al. 2017). The English (a = 0.86; Doram et al. 2017) and the Arabic versions (a = 0.88; Cruz et al. 2018) of the SCS showed remarkable psychometric properties. The validity of the English version of the SCS was established by testing its relationship with expected variables. The findings of Doram et al. (2017) revealed the SCS score correlated with teamwork norms, patient safety norms, disruptive behaviors, burnout, and intention to leave. Furthermore, the same study reported a Cronbach's alpha of 0.86 for the scale (Doram et al. 2017). For the Arabic version, Cruz et al. (2018) reported a Cronbach's alpha ranging from 0.79 to 0.88 and an intraclass correlations coefficient of 0.90 for the two-week test and retest scores. The content validity of the scale was also ascertained with a scale-level content validity index of 0.92 (6 experts). Moreover, the principal component analysis

with varimax rotation revealed a single factor with an explained variance of 73.2% (Cruz et al. 2018). The cultural adaptation of the tool to the Arabic language was reported by Cruz et al. (2018).

The validity and reliability of the SCIPS were reported in a previous study (Musa and Pevalin 2016). The computed Cronbach's alpha of the scale was 0.85. The exploratory factor analysis supported a two-factor structure for the Spiritual Care Intervention-Provision Scale as hypothesised. The SCIPS score correlated with religiosity, further supporting its validity (Musa and Pevalin 2016).

2.3. Ethical Considerations

This study protocol was approved by the administration of the hospitals. The researcher explained the purpose of the research, the rights of the participants, the voluntary participation, and their freedom to withdraw from the study at any point. During the recruitment period, a cover letter containing the information about the study was distributed to the potential participants. Those who approved to participate were asked to sign the informed consent attached to the cover letter. The nurses who signed the informed consent were given the questionnaire and a blank white envelope. No incentive was provided for participation. The use of the scales was permitted by the copyright holders via email.

2.4. Statistical Analysis

Data was analysed using the SPSS version 22. Descriptive statistics, such as mean and standard deviation, were used to identify the spiritual climate and spiritual care provision, whereas frequency count and percentage analysed the "percentage reporting good spiritual climate". ANOVA, independent samples t-test, and Pearson's product moment correlations were utilised to look at the relationship between the spiritual climate and the demographic. If the ANOVA was significant, the Tukey HSD test was carried out for multiple comparisons. The demographic characteristics and perceived spiritual climate were used as predictor variables to predict the spiritual care intervention provisions using a standard multiple regression analysis. P-values lower than 0.05 were considered significant. Confidence intervals (CI) of 95% were also reported, as necessary.

3. Results

The respondents' demographic and work-related profiles are reflected in Table 1. As shown, a vast majority of the respondents was female (87.8%) and was nursing degree holders (72.1%). The respondents' mean age was 30.15 (SD = 6.41). The highest percentage of respondents was Indian (36.9%), followed by Saudi (35.4%) and Filipino (27.7%). Around 48.3% of the respondents were Christians, whereas 41.4% and 10.3% were Muslims and Hindus, respectively. More than half of the respondents were married (51.7%), and the rest were single (48.3%). In terms of work-related characteristics, the respondents were distributed across the seven hospitals, wherein the largest proportion was from Hospital A (23.9%) and the lowest was from Hospital G (7.4%). The majority were employed as staff nurse (79.7%). The mean years of experience as a nurse was 7.32 (SD = 5.71), whilst the mean years of experience as a nurse in Saudi Arabia and in the present hospital were 5.45 (SD = 4.60) and 4.32 (SD = 4.01), respectively.

Table 1. The demographic and work-related variables of the respondents (n = 918).

Variable	n	%
Hospital		
Hospital A	219	23.9
Hospital B	205	22.3
Hospital C	144	15.7
Hospital D	107	11.7
Hospital E	89	9.7
Hospital F	86	9.4
Hospital G	68	7.4
Gender		
Female	806	87.8
Male	112	12.2
Nationality		
Saudi	325	35.4
Indian	339	36.9
Filipino	254	27.7
Religion		
Muslim	380	41.4
Christian	443	48.3
Hindu	95	10.3
Marital status		
Married	475	51.7
Single	443	48.3
Educational attainment		
Diploma in nursing	240	26.1
Baccalaureate in nursing	662	72.1
Graduate studies	16	1.7
Position		
Nursing assistant	94	10.2
Staff nurse	732	79.7
Nursing administration	92	10.0
	Mean (SD)	Range
Age	30.15 (6.41)	20.00–61.00
Total years of experience as a nurse	7.32 (5.71)	1.00–42.00
Total years of experience as a nurse in Saudi Arabia	5.45 (4.60)	1.00–32.00
Total years of experience as a nurse in the present hospital	4.32 (4.01)	1.00–30.00

3.1. Spiritual Climate of Saudi Hospitals as Perceived by Nurses and Its Associated Factors

The spiritual climate of the hospitals was measured by the SCS. The overall mean in the SCS was 64.58 (SD = 24.60), with item 2 "My spiritual views are respected in this clinical area" receiving the highest percentage reporting good spiritual climate (60.2%), and item 1 "I am encouraged to express spirituality in this clinical area" receiving the lowest percentage of reporting good spiritual climate (49.4%; see Table 2).

Table 2. The spiritual climate of hospitals in Saudi Arabia as perceived by nurses (n = 918).

Item	Mean	SD	Percentage Reporting Good Spiritual Climate
1. I am encouraged to express spirituality in this clinical area.	3.50	1.14	49.4%
2. My spiritual views are respected in this clinical area.	3.72	1.06	60.2%
3. My spirituality has a comfortable home in this clinical area.	3.59	1.13	53.5%
4. A diverse set of spiritual views are accepted in this clinical area.	3.53	1.19	54.7%
Overall	64.58	24.60	

As indicated in Table 3, hospital, nationality, religion, position, age, years of nursing experience, and years of experience in Saudi Arabia and in the present hospital were associated with the perceived spiritual climate of the nurses. Specifically, nurses working in Hospital C (M = 71.83, SD = 25.11), Hospital E (M = 76.69, SD = 20.92), Hospital F (M = 74.27, SD = 20.97), and Hospital G (M = 75.64, SD = 25.37) reported significantly better spiritual climate compared with nurses working in Hospital A (M = 61.16, SD = 22.19), Hospital B (M = 56.25, SD = 25.58), and Hospital D (M = 52.92, SD = 18.56). Furthermore, Saudi nurses (M = 68.77, SD = 25.23) reported better spiritual climate perceptions compared with Filipino (M = 63.09, SD = 24.58, p = 0.008) and Indian nurses (M = 61.22, SD = 23.12, p < 0.001). Similarly, Muslim nurses (M = 69.69, SD = 25.64) had significantly better perceptions of their hospital's spiritual climate than Christian nurses (M = 62.40, SD = 23.01, p < 0.001) and Hindu nurses (M = 54.34, SD = 23.01, p < 0.001). Nurses who had administrative functions (M = 75.61, SD = 21.09) also perceived their hospital's spiritual climate more positively compared with nursing assistants (M = 64.76, SD = 25.31, p = 0.007) and staff nurses (M = 63.17, SD = 24.60, p < 0.001). Age (r = 0.15, p < 0.001) and total years of experience as a nurse (r = 0.14, p < 0.001) had a very weak positive correlation with the perceived spiritual climate, whilst the years of experience as a nurse in Saudi Arabia (r = 0.25, p < 0.001) and in the present hospital (r = 0.25, p < 0.001) had a weak positive correlation with perceived spiritual climate.

Table 3. The association between demographic and work-related variables and the spiritual climate perceptions among nurses (n = 918).

Demographic and Work-Related Variable	Spiritual Climate Scale Overall Score		Statistical Test	P
	Mean	SD		
Hospital				
Hospital A	61.16	22.19	F = 21.33	<0.001 ***
Hospital B	56.25	25.58		
Hospital C	71.83	25.11		
Hospital D	52.92	18.56		
Hospital E	76.69	20.92		
Hospital F	74.27	20.97		
Hospital G	75.64	25.37		
Gender				
Female	64.57	24.38	t = −0.04	0.966
Male	64.68	26.26		
Nationality				
Saudi	68.77	25.23	F = 7.82	<0.001 ***
Indian	63.09	24.58		
Filipino	61.22	23.12		

Table 3. *Cont.*

Demographic and Work-Related Variable	Spiritual Climate Scale Overall Score		Statistical Test	p
	Mean	**SD**		
Religion				
Muslim	69.69	25.64	F = 18.86	<0.001 ***
Christian	62.40	23.01		
Hindu	54.34	23.01		
Marital status				
Married	65.43	24.34	t = 1.09	0.278
Single	63.67	24.87		
Educational attainment				
Diploma in nursing	67.71	24.33	F = 2.82	0.060
Baccalaureate in nursing	63.39	24.75		
Graduate studies	67.19	18.33		
Position				
Nursing assistant	64.76	25.31	F = 10.67	<0.001 ***
Staff nurse	63.17	24.60		
Nursing administration	75.61	21.09		
Age			r = 0.15	<0.001 ***
Total years of experience as a nurse			r = 0.14	<0.001 ***
Total years of experience as a nurse in Saudi Arabia			r = 0.25	<0.001 ***
Total years of experience as a nurse in the present hospital			r = 0.25	<0.001 ***

*** Significant at a p < 0.001 level.

3.2. Spiritual Care Interventions Provision and the Influence of the Hospitals' Spiritual Climate

The provision of spiritual care intervention was measured using the SCIPS. The overall mean in the SCIPS was 56.83 (SD = 9.46, range = 17.00–68), indicating that the nurses always provided spiritual care to their patients. For its subscales, the mean score in the existential items was 31.61 (SD = 4.82, range = 9–36), whereas the mean score in the religious items was 25.22 (SD = 5.41, range = 8–32). The existential items' means ranged from 3.35 (SD = 0.83) to 3.67 (SD = 0.62), whilst the religious items' means ranged from 2.75 (SD =1.13) to 3.42 (SD = 0.80). These findings imply that nurses tend to provide existential spiritual care more often than religious spiritual care interventions (see Table 4).

Table 4. The spiritual care interventions provision among nurses (n = 918).

Items	Mean	SD
Existential items	31.61	4.82
1. Listen actively to your patients talk about their religious/spiritual beliefs, practices, and beliefs about God	3.35	0.83
2. Give your patients the opportunity to talk about God and support coming from God in time of illness	3.35	0.78
10. Respect patients' privacy, dignity, religion, and religious and spiritual beliefs and rituals	3.66	0.61
12. Help your patients to become aware of meaning and purpose of life in facing and suffering from illness	3.46	0.75
13. Spend time with your patients giving comfort, support, and reassurance when needed	3.54	0.73
14. Create a feeling of kindness, cheerfulness, and intimacy when giving care to your patients	3.65	0.66

Table 4. *Cont.*

Items	Mean	SD
15. Help your patients to feel hopeful and to keep a positive outlook	3.67	0.62
16. Encourage laughter or introduce appropriate humour	3.52	0.70
17. Hold your patients' hand or put your hand over their shoulders to give them support and reassurance	3.41	0.77
Religious items	25.22	5.41
3. Offer to read from the Qur'an on your patients or to share prayer and meditation with them	2.82	1.06
4. Provide your patients with a suitable place to pray, read the Qur'an, meditate, and/or do ablution	3.42	0.80
5. Facilitate the utilization of religious/spiritual resources available in the hospital (e.g., common prayer room, the Holy Qur'an book, rosary, prayer rug, and/or prayer direction signs)	3.36	0.84
6. Help your patients listen to religious programs on radio or TV if available	3.14	0.94
7. Give them the opportunity to participate in religious or spiritual events arranged on the ward (e.g., praying with others or visiting other patients in the hospital)	3.20	0.89
8. Offer to discuss with your patients the difficulties of practicing prayer when sick and the proper ways of washing and cleaning their bodies and clothes for praying	3.13	0.90
9. Arrange a visit by the hospital imam to comfort and support your patients if requested by them	2.75	1.13
11. Give patients' family or close friends the opportunity to visit your patients, to share prayer, to read from the Qur'an, and to meditate with them	3.39	0.81
Overall	56.83	9.46

The overall mean in the SCS, together with the demographic and work-related characteristics, was entered as predictor variables in a multiple linear regression to predict the spiritual care intervention provision. The regression model was statistically significant (F [21, 896] = 9.16, p < 0.001) and accounted for approximately 15.5% (R^2 = 0.177; adjusted R^2 = 0.157) of the variance in the spiritual care intervention provision of nurses. As reflected in Table 5, the hospital, the position, the years of experience in the present hospital, and the hospital's spiritual climate were identified as significant predictors of the nurses' spiritual care interventions provision. Nurses working in Hospitals A, E, and G had higher SCIPS mean scores by 2.74 (p = 0.003, 95% CI = 0.91, 4.58), 6.36 (p < 0.001, 95% CI = 4.03, 8.69), and 4.52 (p < 0.001, 95% CI = 2.01, 7.02), respectively, than nurses working in Hospital B. Nurses with administrative functions likewise reported a significantly more frequent provision of spiritual care interventions than nursing assistants (ß = 3.39, p = 0.028, 95% CI = 0.36, 6.43). Moreover, a year increase in the experience of the nurses in their present hospital showed a 0.39 point (p = 0.012, 95% CI = −0.69, −0.09) decrease in the SCIPS score, indicating that the provision of spiritual care interventions tends to decrease as the nurses' years of experience in their hospital increase. Finally, a point increase in the SCS score increased the SCIPS score by 0.11 (p < 0.001, 95% CI = 0.08, 0.13), implying that the more positive the nurses perceived their hospital's spiritual climate, the greater the spiritual care interventions they provided to their patients.

Table 5. The factors influencing the spiritual care intervention provisions among nurses (n = 918).

Predictor Variables	ß	SE-b	Beta	t	p	95% CI Lower	Upper
Hospital (Reference group: Hospital B)							
Hospital A	2.74	0.94	0.12	2.93	0.003 **	0.91	4.58
Hospital C	1.89	0.98	0.07	1.92	0.055	−0.04	3.80
Hospital D	1.78	1.16	0.06	1.53	0.126	−0.50	4.07
Hospital E	6.36	1.19	0.20	5.35	<0.001 ***	4.03	8.69
Hospital F	0.22	1.26	0.01	0.17	0.864	−2.26	2.70
Hospital G	4.52	1.28	0.13	3.54	<0.001 ***	2.01	7.02
Gender	−0.99	1.01	−0.03	−0.98	0.329	−2.97	1.00
Nationality (Reference group: Saudi)							
Filipino	2.84	1.49	0.15	1.91	0.057	−0.09	5.77
Indian	1.05	1.32	0.05	0.80	0.423	−1.53	3.63
Religion (Reference group: Muslim)							
Christian	−1.46	1.32	−0.08	−1.11	0.266	−4.04	1.12
Hindu	−2.29	1.75	−0.07	−1.31	0.192	−5.72	1.15
Marital status	1.16	0.63	0.06	1.84	0.066	−0.08	2.41
Educational attainment (Reference group: Diploma in nursing)							
Baccalaureate in nursing	0.44	0.81	0.02	0.54	0.589	−1.15	2.02
Graduate studies	1.06	2.31	0.02	0.46	0.648	−3.48	5.60
Position (Reference group: Nursing assistant)							
Staff nurse	2.14	1.25	0.09	1.72	0.086	−0.30	4.59
Nursing administration	3.39	1.54	0.11	2.20	0.028 *	0.36	6.43
Age	−0.04	0.10	−0.03	−0.38	0.706	−0.23	0.16
Total years of experience as a nurse	0.04	0.13	0.02	0.28	0.783	−0.22	0.30
Total years of experience as a nurse in Saudi Arabia	0.21	0.18	0.10	1.16	0.247	−0.15	0.57
Total years of experience as a nurse in the present hospital	−0.39	0.15	−0.17	−2.53	0.012 *	−0.69	−0.09
Perceived spiritual climate	0.11	0.01	0.28	8.19	<0.001 ***	0.08	0.13

The nurses' self-reported spiritual care intervention provision was the dependent variable. β is the unstandardized coefficients; SE-*b* is the standard error. Beta is the standardized coefficients. R^2 = 0.177; Adjusted R^2 = 0.157. * $p < 0.05$, ** $p < 0.01$, and *** $p < 0.001$.

4. Discussion

The findings provide evidence resulting from the examination of the influence of the workplace spiritual climate on the nurses' provision of spiritual care in seven hospitals in Saudi Arabia. Nurses presented a good spiritual climate condition in clinical health settings. The result is similar to a past study conducted among 165 Saudi nurses in Saudi Arabia, which recognised a good spiritual climate in the hospital (Cruz et al. 2018). A good spiritual climate in a clinical practice environment provides a significant sense of purpose and improved life fulfillment (Cruz et al. 2018). This result is expected from a country with conservative religious and spiritual values. This finding is also in agreement with the results of a study conducted on other Muslim countries, such as Jordan (Melhem et al. 2016) and Malaysia (Kaur et al. 2013). In the survey conducted by Doram et al. (2017), they revealed that US nurses regarded good spiritual condition as critical in facilitating suitable spiritual nursing care. Additionally, the greater spiritual condition among nurses tends to lead to better patient care (Doram et al. 2017). Pirkola et al. (2016) used an integrated literature review of 632 studies and revealed that the higher spiritual condition leads to greater work productivity and performance compared with a lower spiritual climate in clinical practice. Therefore, the spiritual condition of nurses is critical for quality healthcare.

In terms of demographic and work-related factors, a different hospital type is significantly associated with and predicts spiritual care intervention provision. The result is in agreement with the previous empirical data in which spiritual climate varies differently in each hospital (Cruz et al. 2018; Doram et al. 2017). According to Ross et al. (2014), several features of spirituality contents (e.g., higher power, morality, faith, values, love, and relationships) make an individual unique. These features most

likely provide a possible explanation for the variations. Similarly, Pirkola et al. (2016) explained that different types of hospitals have different organisational cultures and that different leadership styles influence the workplace spirituality perception. This combination of previous literature supports the findings of the study. Hence, exploring these variations can positively affect spiritual care among nurses and is an interesting topic for future research.

Another important finding was that Saudi nurses and Muslim nurses reported a better spiritual climate perception than expatriate nurses (e.g., Filipino nurses and Indian nurses). This implies that Muslims had significantly better perceptions of their hospital's spiritual climate than nurses who were Christians and Hindus. Saudi Arabia is religious, conservative, and predominantly practices traditional Islam, which plays a significant role in the provision of care by non-Muslim nurses in this country compared with other Muslim countries (Almutairi 2015). Only Islam is allowed and practiced in Saudi Arabia. Non-Muslims working in the country are not allowed to practice their religion in public (World Report 2015). Due to such restrictions, non-Muslim nurses may be uncomfortable to practice in their own spiritual faith. Although the government allows non-Muslims to practice their own spiritual faith privately, this policy has no clear guidelines and is not consistently enforced (Almutairi 2015). This restriction may present a challenge not only to the spirituality of non-Muslim nurses but also to the provision of spiritual care (Almutairi 2015). Nevertheless, understanding the differences in spiritual perception allows nurses to tailor the care provided to fit the spiritual values, beliefs, and practices in rendering quality patient care (Cruz et al. 2018).

Nurses with administrative functions perceived better spiritual climate in the hospital compared with nursing assistants and staff nurses. According to Tracy et al. (2004), nurses with administrative functions is one of the roles of the nursing administrator. The majority of nursing administrators in the country are Saudi nationals, whereas nursing assistants and staff nurses are predominantly expatriate nurses (Alboliteeh et al. 2017). Possibly, the nursing administrators are comfortable in practicing their spiritual faith than expatriate nurses. This also accords with earlier observations which showed that staff nurses and nursing assistants are burdened with a heavy workload, many responsibilities, and being responsible for the patients' health and treatment (Pirkola et al. 2016). Spiritual activities may disrupt nurses' routine at work and may delay carrying out specific duties (Pirkola et al. 2016). Therefore, it is possible that they have less time for spiritual reflection than nursing administrators. However, this result should be interpreted with caution as these issues and challenges in healthcare settings among staff nurses and nursing assistants in relation to spiritual faith were not measured in the study. Thus, this research gap warrants further exploration.

The findings revealed that age is significantly associated with the perceived spiritual climate of the nurses. In this study, a large proportion of the respondents were considered young adults (McDonagh and European Training Effective Care, and Health Faculty 2018). According to Zakaria Kiaei et al. (2015), young adulthood is a time of holistic thinking, in which young people begin to become aware of complexities in life. This is also the stage when people recognise the totality of the human being and aids healing processes including spiritual requirements (Zakaria Kiaei et al. 2015). The nursing profession is perceived as laborious, complicated, and highly demanding. In the study of Rudolfsson et al. (2014), some young adult nurses described that spiritual faith sustained them despite the great job demands and highly stressful responsibilities. Hence, the good spiritual perceptions of young adult nurses can directly influence their performance and quality patient care.

Another important highlight of this study is that the nurses' years of experience and years of working as a nurse in Saudi Arabia are significantly related to the perceived spiritual climate. This is supported by the previous study, which could be related to the length of experience influencing the perceived spiritual climate (Cruz et al. 2018). Thus, experience may create spiritual competence. Additionally, experience in the present hospital is associated with and is a remarkable predictor of the nurses' spiritual care interventions provision. This means that a longer exposure in the spiritual climate, the greater spiritual care will be provided for patients. According to Walker and Breitsameter (2017), spiritual care interventions are intertwined with long years of experience in administering patient care.

It is almost certain that adequate work experience appears to promote an understanding in evaluating spiritual care interventions among patients (Melhem et al. 2016). In a country in which Muslim faith dominates the healthcare settings, nurses should have a higher understanding of their spiritual care competence (World Report 2015). Nevertheless, competence in nursing regarding spiritual care was not measured in the study. Therefore, further research in spiritual care competence spiritual care could be recommended.

In the current study, nurses tend to provide existential spiritual care more often than religious spiritual care interventions. This is worth noting because the previous study revealed that nurses believed that religious spiritual care interventions reside with experts, such as imam, rather than by nurses (Ronaldson et al. 2012). Nurses also deliver existential spiritual care more than religious interventions, which may be due to the fact that the majority of the respondents are non-Muslim. Hence, it is likely that they may not be comfortable to practice religious interventions. Thus, these different issues regarding the complexity of the nurses' spiritual care and how different individuals may express it are important topics for future research.

Finally, this study found that nurses perceived the spiritual climate influences their spiritual care interventions provisions. A previous study highlighted that understanding nurses' spiritual care improves their spiritual care interventions (Kaddourah et al. 2018). In the study of Ronaldson et al. (2012), they found that positive spiritual climate promotes high-quality care. When nurses are holistically aware of the role of spiritual care provision, this empowers them to deliver optimum care and aid to avoid confusion among other healthcare professionals, patients, and their families (Alboliteeh et al. 2017). For instance, rendering spiritual care may boost huge respect from Muslim patients, which signifies the acceptance of the patients' cultures and beliefs (Almutairi 2015). Additionally, nurses who provide good spiritual climate experience less medication errors, better therapeutic communication education, and greater adherence of the patient to the medical regimen (Alosaimi 2013). This result also corroborates the findings in one study in the US (Mamier and Taylor 2015) and Australia (Ronaldson et al. 2012). Spiritual care has emerged as a powerful platform because it is a part of the Arab Muslim patients' needs assessment (Lovering 2012). Although empirical data showed good spiritual climate in the workplace, some nurses rarely deliver spiritual care to their patients (Gallison et al. 2013). Nonetheless, spiritual guidance and continuing education programs for nurses' spiritual care development could be recommended in the future.

Some limitations should be acknowledged and considered when utilising the findings of this study. This study was conducted on a conveniently selected sample at a particular time. This method may pose a challenge in generalising conclusions drawn from the research. Concluding causality is also difficult because the study used a cross-sectional design. The study was administered in public hospitals, which the results of may differ from those of private hospitals. The concept of spirituality is multifaceted and complex in nature; hence, determining the nurses' perception of spiritual care through a self-administered survey may not accurately mirror all insights. Also, the study did not inquire about the specific ethnic backgrounds of the respondents, as well as whether the respondents practice their religion. Hence, future studies should consider inquiring about this information to have a deeper understanding about these variables. Finally, nurses' spiritual care implementations are reliant on the milieu where they are implemented. A spiritual care that has been shown to be effective in one setting may not necessarily be effective to another health care setting, especially when spiritual care is implemented in a multicultural hospital. Contextually, spiritual climate and spiritual care cannot be easily measured by quantitative means because it is a subjective, dynamic, and complex construct that transpires from an individual's sociocultural environment and political and organizational system. Therefore, future studies (qualitative studies) are needed in order to determine the spiritual care interventions' transferability from the locale of the study setting to another health care setting and to decrease substantial uncertainty.

However, despite these limitations, it may not undermine the study purpose. One of the most significant findings is identifying the key factors that affect spiritual climate perceptions and the

spiritual care provision of nurses. The survey exhibited high reliability and response rates. In addition, the study was conducted in seven hospitals, ensuring that the questionnaire results adequately represented the target population. The results contributed to the limited literature on the factors influencing the spiritual climate and spiritual care intervention provision among nurses in their current jobs in Saudi Arabia.

5. Conclusions and Implications

This study highlighted the factors that influence workplace spiritual climate on the nurses' provision of spiritual care in seven hospitals in Saudi Arabia. Nurses in Saudi have a positive spiritual climate towards hospitals. Spiritual climate perception among nurses varies differently from each hospital. Nurses' spiritual climate is influenced by demographic and work-related characteristics. Saudi nurses, nurses with administrative functions, Muslim faith, age, and years of experience as a nurse in Saudi Arabia and in the present hospital are important determinants of their perceived spiritual climate. Overall, nurses have a positive provision of spiritual care to their patients. Results also indicated that different types of hospital, nurses with administrative tasks, a longer tenure in the present hospital, and a positive spiritual climate influences the spiritual care interventions among nurses.

The study gives direction regarding comprehensive spiritual care interventions and classifies where nurses could receive spiritual care workshops and training to be more competent. The administration needs to be aware of factors associated with spiritual climate and spiritual care interventions, such as nationality, nurses' job description, religion, nurses' age, and years of experience as a nurse in Saudi Arabia and in the present hospital. Nursing management should initiate promoting and improve education and training in spiritual care, which should be incorporated into clinical practice. Understanding and respecting spiritual differences might enable nurses to connect with, respond to, and interact effectively with their patients. This can be achieved by creating a spiritually friendly workplace environment where non-Muslim nurses can fit in the spiritual care, beliefs, and practices in rendering quality patient care. The improvement of nurses' spiritual awareness and spiritual care are important, especially for newly recruited expatriate nurses. Furthermore, it is important to reflect certain spiritual care interventions through policies so that nurses can be actively engaged, thereby fulfilling their patients' spiritual needs and encouraging their adherence to quality standards.

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