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Spirituality and Spiritual Care Competence among Expatriate Nurses Working in Saudi Arabia

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Abstract: Background: In Saudi Arabia, where the majority of the nursing workforce are foreigners, little is known about perceptions of spirituality and spiritual caregiving among foreign nurses who provide nursing care to patients with varied spiritual and religious beliefs. Therefore, this study was conducted to investigate the spirituality and spiritual care competence and its predictors among expatriate Christian nurses in Saudi Arabia, who provide care for Muslim patients. Methods: A convenience sample of 302 nurses was surveyed in this descriptive cross-sectional study using the Spirituality and Spiritual Care Rating Scale and the Spiritual Care Competence Scale. Results: Results revealed high values on three domains, namely, spiritual care, personal care, and existential spirituality. The majority of the respondents reported competence in all six subscales of spiritual care. The participants' age, educational level, perception of existential spirituality, and personal care were found to be relevant predictors of their spiritual care competence. Conclusions: The findings suggest that existential spirituality and personal care dimensions of Christian nurses' spirituality and spiritual care perceptions play critical roles in the provision of competent spiritual care to Muslim patients.

Keywords: Christians; Saudi Arabia; spirituality; spiritual care competence; spiritual nursing care

1. Introduction

Various elements of nursing care are well understood and developed; however, spiritual care has yet to be completely elucidated. Previous research has indicated that attending to the spiritual needs of patients results in positive outcomes (Ramezani et al. 2014). However, the provision of spiritual care to patients faces many challenges, such as gender differences (Melhem et al. 2016), inadequate time, staffing issues, and lack of academic preparation, including the nurses' own perception toward spirituality and spiritual care, which affect their competence in delivering quality service (Chan 2010). Although spirituality is a known phenomenon, spiritual care in other settings may be different due to a culture-specific aspect, including nurses' religious and spiritual approaches in a clinical environment (Schultz et al. 2014). Thus, many scholars have recommended an increase in studies about nursing spiritual care in different settings to develop a clearer understanding about this phenomenon (Bowers and Rieg 2014; Labrague et al. 2016; Cruz et al. 2016a, 2016b). As Atkinson (2015) posited, with a greater understanding of the role of spirituality and healing, we may be able to investigate several ways to deliver spiritual understanding and growth among nurses.

The birth of Christianity allowed the emergence of the concept of the intrinsic dignity of all persons and spirituality as compassionate accompaniment. This philosophy drove nursing to develop and flourish in Europe. Across seven centuries, the fundamental nursing impulse was always spiritual. Spirituality has been integrated in nursing care since the time of Nightingale (Meehan 2012). In the 20th century, the concept of spirituality and spiritual care in nursing re-emerged based on the consensus of

studies. The literature reported nurses with varying perceptions of spirituality and different competence levels in attending to the spiritual needs of patients across nations (Adib-Hajbaghery et al. 2017; Chan 2010; Ozbasaran et al. 2011; Zakaria Kiaei et al. 2015). Moreover, the results of these studies, in general and in the Middle East, come from specific healthcare settings without focusing on Christian nurses and their working background.

Spirituality is regarded as a means of being in the world, by which an individual views life with meaning and purpose, believes in a higher power, and has a sense of connection to oneself and to others (Weathers et al. 2015). Spirituality is also possibly influenced by culture (Baldacchino 2006; Chan 2010). In terms of the religious aspect of spirituality, Christianity is not the first place where compassion is described—Buddhism, Hinduism, and other faiths are clear examples of principles of compassion and dignity. In Islam, Jesus is recognized as a holy person and an example of compassion. Islam also teaches compassion and dignity.

Several studies have indicated the manner by which a nurse connects to his or her perspective of spirituality and spiritual care. A literature review revealed that the spirituality of health care providers influences their delivery of spiritual care to patients (Kalish 2012). These studies were conducted in Hong Kong (Chan 2010), the Philippines (Labrague et al. 2016), and the United Kingdom (McSherry and Jamieson 2011). However, only a few studies have been conducted on this topic in the Middle East (Cruz et al. 2017a, 2016b). For example, Ozbasaran et al. (2011) found that nurses in three public hospitals in Turkey have unclear perceived spirituality and spiritual care; their educational level, belief in the evil eye, and practice area had a positive impact on their perception of spirituality. Similarly, Baird (2016) found that Muslim nurses in nine government and private hospitals in Jordan provided infrequent spiritual interventions to patients, and their spiritual wellbeing was positively associated with the frequency of the delivery of spiritual care interventions. In Iran, Zakaria Kiaei et al. (2015) reported that the overall average for spirituality and spiritual care perception among Iranian Muslim nurses in six educational hospitals was moderate, and a significant relationship was also found between education level and spiritual care. Indeed, the nurses' perception of their spirituality affected their provision of spiritual nursing care.

Spiritual care competencies in nursing involve a set of skills used in professional nursing practice and within the framework of the nursing process, resulting in a positive outcome (Van Leeuwen et al. 2009). Studies show that nurses lack confidence and competence in providing spiritual care (Ruder 2013; Taylor 2012). Additionally, in the Netherlands, Van Leeuwen and Almutairi (2015) indicated that nurses in mental health and home care settings have a generic view of spirituality and are more competent in delivering spiritual care than nurses in hospital settings. In Iran, Adib-Hajbaghery et al. (2017) found that three-fourths of Iranian nurses in teaching hospitals included in their study demonstrated unfavorable competence in spiritual care. As Van Leeuwen and Almutairi (2015) pointed out, spiritual care competence may be related to individual characteristics such as age, gender, working experience, and personal views of spirituality, which can lead to variations in their competence of providing spiritual care.

The interfaith model of spiritual care emerged to bring light to the complex and hybrid identity of spiritual care (Ganzevoort et al. 2014). Interfaith spiritual care was defined as a "situation wherein caregiver and patient have different spiritual, religious, nonspiritual, or nonreligious worldviews" (Liefbroer et al. 2017, p. 1777). In Saudi Arabia, the nursing workforce is diverse, comprising Saudi and other nationalities (Cruz 2017). Most foreign nurses are Filipinos and Indians, who believe in Christianity. Christians in the Middle East account for 3.8% of the 2.2 billion Christians worldwide (Pew Research Center 2011). Regardless of their religion, nurses are expected to be competent in providing holistic care to their patients. Interfaith spiritual care is expected to be expertly provided by Christian nurses to their Muslim patients. However, the practice of interfaith spiritual care has been contested due to several challenges (Liefbroer et al. 2017). For example, Christian nurses who provide spiritual care to patients with varying religious beliefs may be challenged, especially in maintaining professional and religious integrity (Fawcett and Noble 2004). Furthermore, Christian nurses may find

themselves in two opposing poles when attending to the spiritual needs of patients with different faiths: "they may feel bound to do all in their power to bring those in their care into a relationship with God, through Jesus, in order that they might find the answer to their spiritual needs, and on the other hand may feel that this approach would not be seen as acceptable by colleagues" (Fawcett and Noble 2004, p. 140).

In Saudi Arabia, where life is greatly influenced by their Islamic faith, the religious aspect of spiritual care is vital in the fulfillment of holistic care to Saudi patients. However, efforts to provide quality care in Saudi Arabia might be jeopardized by differences in religion (Aboshaiqah 2016). When patients' spiritual needs are met alongside with the other components in the provision of care, patient satisfaction increases (Cruz et al. 2016b); a holistic care goal for Saudi Muslim patients is achieved. Although a considerable amount of studies have been conducted on spiritual care among nurses, results may not apply to the present research because it may not quantitatively capture the result coming from Christian nurses, whose religion and culture are different from their patients. Furthermore, little is known about whether Christian nurses who work in a vastly religious country are competent in providing spiritual care to patients with Islamic faith. Therefore, this study was conducted to assess the nurses' perceptions of spirituality and spiritual care and investigate their competence in providing spiritual care to Muslim patients. It also examined the predictors of the nurses' spiritual care competence for Muslim patients.

2. Materials and Methods

2.1. Design

This study utilized a descriptive, cross-sectional design.

2.2. Setting and Participants

This study was conducted in two public hospitals in the central region of Saudi Arabia and included a convenience sample of 302 Christian nurses. Participants were considered eligible to take part in the study if they were (1) a Filipino or Indian national; (2) a Christian; (3) had more than 6 months of clinical experience in the hospital; and (4) willing to participate. Filipino and Indian Christian nurses were included in the study because they comprise the highest proportion of expatriate nurses in the country and for the reason that the study wanted to emphasize on the interfaith spiritual care competence of Christian nurses in an Islamic country. Foreign nurses working in the two hospitals were all females; hence, the study was limited to female Filipino and Indian nurses. A total of 347 nurses who satisfied the inclusion criteria were invited to participate. Only 302 participated in the study, resulting in a response rate of 87.0%.

2.3. Instrument

A survey questionnaire with three parts was used to collect data from the respondents. The first part of the survey was tailored to capture the respondents' demographics, such as nationality, age, gender, clinical experience, highest educational attainment, previous spiritual nursing course/seminar, and area of practice (categorized as specialty or non-specialty).

The second part of the questionnaire utilized the Spirituality and Spiritual Care Rating Scale (SSCRS) to determine the nurses' perception on spirituality and provision of spiritual care (McSherry et al. 2002). In this study, the adapted SSCRS comprised 15 items that were categorized under four subscales: existential spirituality (5 items), spiritual care (4 items), religiosity (3 items), and personal care (3 items). In the original study conducted by McSherry et al. (2002), item "c" (I believe spirituality is concerned with a need to forgive and a need to be forgiven.) was dropped from the final data set, because this variable loaded significantly on Factors 1 (existential spirituality) and 2 (spiritual care). Likewise, item "e" (I believe spirituality is not concerned with a belief and faith in a God or a Supreme Being.) was dropped, because it is the only item in Factor 5, leaving 15 items on

the adapted tool. Each item in this tool was rated on a five-point Likert scale ranging from "strongly disagree" (5) to "strongly agree" (1). Negatively worded items were reverse-scored. High scores indicated excellent perceptions of spirituality or great levels spiritual care. The SSCRS demonstrates adequate validity and reliability. It has an acceptable internal consistency with a Cronbach's alpha coefficient of 0.64 (McSherry et al. 2002). In this study, the Cronbach alpha was 0.74, indicating good internal consistency.

The third part of the questionnaire measured the respondents' perception of their spiritual care competence using the Spiritual Care Competence Scale (SCCS; Van Leeuwen et al. 2009). The SCCS consisted of 27 items in six subscales: assessment and implementation of spiritual care (6 items), professional development and improving the quality of spiritual care (6 items), personal support and patient counseling (6 items), referral to professionals (3 items), communication (2 items), and attitude toward patients' spirituality (4 items). Each item was rated on a five-point Likert scale ranging from "completely disagree" (1) to "completely agree" (5). An overall high score indicated high levels of perceived competency. The SCCS is a valid and reliable measure of spiritual care competence with Cronbach alpha scores ranging from 0.56 to 0.82 (Van Leeuwen et al. 2009). In this study, the Cronbach alpha was 0.89, indicating good internal consistency.

To put the study in context, the questionnaire included a statement saying that the respondents should answer the scales based on their experience in caring for patients with Islamic faith in Saudi Arabia.

2.4. Data Collection and Ethical Considerations

The study protocol was reviewed by the researcher's institution. Data were collected between January and April 2016. After securing permission from the hospitals, the researcher approached the participants during their shift breaks or during periods when they were not actively involved in patient care (morning and afternoon shifts). Respondents were accommodated in the nursing lounge of their practice area. Considerable information about the study and consent process, including the participant's rights, was presented. Nurses who agreed to participate were asked to sign the informed consent form. The confidentiality and anonymity of each participant were maintained, and no identity information was included in the questionnaire. Moreover, an envelope was provided for them to enclose and seal the completed questionnaire. The participants were given adequate time to complete the survey. No incentives were given to the participating hospitals and nurses. Permission from the copyright holder of the tools was obtained before data gathering.

2.5. Data Analysis

Data were analyzed using Statistical Package for Social Sciences version 22.0. Frequency count and percentage were used to fully describe the demographic characteristics of the respondents. Means and standard deviations were calculated for perceived spirituality and spiritual care, as well as spiritual care competence. Inferential statistics, such as bivariate analyses and multiple regressions, were employed to determine possible associations among relevant variables. Statistical significance was set at $p < 0.05$.

3. Results

As reflected in Table 1, nearly half of the respondents were aged between 23 years old and 29 years old (49%). In terms of nationality, the sample was evenly distributed with 152 (50.3%) Filipino and 150 (49.7%) Indian nurses. Majority of the respondents were married (52.3%), had a Bachelor of Science in Nursing (BSN) degree (80.1%), were working in non-specialty areas (62.9%), had 3–9 years of clinical working experience (55.0%), had spiritual nursing courses in the curriculum of their most recent nursing program attended (80.8%), and had not attended spiritual care-related seminars in the last 12 months (56.3%).

Table 1. Demographic characteristics of the respondents (n = 302).

Demographics		***n***	**%**
Age	23–29 years	148	49.0
	30–39 years	82	27.2
	40–49 years	32	10.6
	50–60 years	40	13.2
Marital status	Single	144	47.7
	Married	158	52.3
Nationality	Filipino	152	50.3
	Indian	150	49.7
Educational level	BSN	242	80.1
	Diploma	60	19.9
Area of practice	Non–specialty	190	62.9
	Specialty	112	37.1
Clinical experience	<3 years	38	12.6
	3–9 years	166	55.0
	10–19years	62	20.5
	>20 years	36	11.9
Previous spiritual nursing course	Yes	244	80.8
	No	58	19.2
Attended spiritual care seminars in the past 12 months	Yes	132	43.7
	No	170	56.3

Note. BSN is Bachelor of Science in Nursing

3.1. Perceptions of Spirituality and Spiritual Care

Table 2 reflects the perceptions on spirituality and spiritual care of the respondents. As indicated, the spiritual care dimension received an overall mean score of 4.13 (SD = 0.49), whereas personal care and existential spirituality received mean scores of 4.05 (SD = 0.61) and 4.00 (SD = 0.51), respectively. The respondents reported poor perceived religiosity, as indicated by a mean score of 2.63 (SD = 0.60).

Table 2. Spirituality and Spiritual Care Rating Scale (SSCRS) mean subscale scores and their association with the demographic characteristics (n = 302).

Demographics	**Existential Spirituality**		**Spiritual Care**		**Religiosity**		**Personal Care**	
	Mean ± SD	**F/t**	**Mean ± SD**	**F/t**	**Mean ± SD**	**F/t**	**Mean ± SD**	**F/t**
Age								
23–29 years	4.06 ± 0.44	F = 0.73	4.11 ± 0.44	F = 1.21	2.73 ± 0.62	F = 2.20	4.10 ± 0.56	F = 2.19
30–39 years	3.98 ± 0.61		4.22 ± 0.57		2.47 ± 0.41		4.11 ± 0.64	
40–49 years	3.89 ± 0.50		3.95 ± 0.34		2.75 ± 0.56		4.06 ± 0.47	
50–60 years	3.92 ± 0.56		4.13 ± 0.56		2.50 ± 0.81		3.73 ± 0.76	
Marital status								
Single	4.13 ± 0.44	t = 2.99 **	4.25 ± 0.42	t = 2.99 **	2.63 ± 0.60	t = 0.06	4.19 ± 0.59	t = 2.78 **
Married	3.88 ± 0.55		4.02 ± 0.51		2.63 ± 0.61		3.92 ± 0.60	
Nationality								
Filipino	4.09 ± 0.51	t = 2.25 *	4.23 ± 0.45	t = 2.72 **	2.66 ± 0.64	t = 0.55	4.11 ± 0.61	t = 1.06
Indian	3.91 ± 0.51		4.02 ± 0.50		2.60 ± 0.57		4.00 ± 0.61	
Educational level								
BSN	4.10 ± 0.47	t = 5.05 ***	4.21 ± 0.46	t = 4.47 ***	2.64 ± 0.61	t = 0.54	4.13 ± 0.59	t = 3.19 **
Associate	3.61 ± 0.49		3.79 ± 0.50		2.58 ± 0.55		3.74 ± 0.61	

Table 2. *Cont.*

Demographics	Existential Spirituality		Spiritual Care		Religiosity		Personal Care	
	Mean ± SD	F/t	Mean ± SD	F/t	Mean ± SD	F/t	Mean ± SD	F/t
Area of practice								
Non-specialty	3.97 ± 0.47	t = −1.05	4.08 ± 0.51	t = −1.55	2.65 ± 0.65	t = 0.38	4.02 ± 0.54	t = −0.87
Specialty	4.06 ± 0.58		4.21 ± 0.44		2.61 ± 0.50		4.11 ± 0.71	
Clinical experience								
<3 years	4.07 ± 0.50	F = 0.28	4.18 ± 0.45	F = 0.22	2.56 ± 0.78	F = 0.59	4.19 ± 0.55	F = 1.68
3–9 years	4.00 ± 0.42		4.12 ± 0.42		2.68 ± 0.54		4.09 ± 0.56	
10–19years	3.94 ± 0.68		4.08 ± 0.63		2.53 ± 0.47		4.03 ± 0.66	
>20 years	4.03 ± 0.61		4.17 ± 0.61		2.67 ± 0.83		3.78 ± 0.77	
Previous spiritual nursing course								
Yes	3.98 ± 0.52	t = −0.97	4.10 ± 0.50	t = −1.43	2.63 ± 0.60	t = −0.12	4.04 ± 0.62	t = −0.49
No	4.08 ± 0.49		4.24 ± 0.41		2.64 ± 0.62		4.10 ± 0.58	
Attended spiritual care seminars in the past 12 months								
Yes	3.98 ± 0.52	t = −0.45	4.09 ± 0.52	t = −0.86	2.55 ± 0.58	t = −1.46	3.97 ± 0.56	t = −1.48
No	4.02 ± 0.51		4.16 ± 0.46		2.69 ± 0.61		4.12 ± 0.64	

Note. * Significant at 0.05 level, ** Significant at 0.01 level, *** Significant at 0.001 level. F is the F value and t is the t value.

Nurses who were single had better perceptions of existential spirituality (t = 2.99, $p = 0.003$), spiritual care (t = 2.99, $p = 0.003$), and personal care (t = 2.78, $p = 0.006$) than those who were married. Furthermore, Filipino nurses reported better perceptions of existential spirituality (t = 2.25, $p = 0.026$) and spiritual care (t = 2.72, $p = 0.007$) than Indian nurses. Nurses who held a BSN degree also exhibited better perceptions on existential spirituality (t = 5.05, $p < 0.001$), spiritual care (t = 4.47, $p < 0.001$), and personal care (t = 3.19, $p = 0.002$) than those who only held an associate diploma. No association was found between the demographic characteristics of the respondents and their perceived religiosity.

3.2. Perceived Competence in Delivering Spiritual Care

The mean SCCS score was 3.93 (SD = 0.42). Based on the cutoff point of >3.5, more than three-fourths of respondents (79.5%) perceived themselves to be competent in delivering spiritual care to patients with Islamic faith, whereas 20.5% did not. In terms of the subscales, the respondents perceived to be competent in all the six subscales using the cutoff point of >3.5, with the highest reported competence on attitude toward patients' spirituality (M = 4.14, SD = 0.60) and lowest in assessment and implementation of spiritual care (M = 3.79, SD = 0.62). Majority of the respondents reported competence in all the six subscales of the SCCS, with a percentage range of 66.2–78.1 (see Table 3).

Table 3. Spiritual Care Competency Scale (SCCS) mean subscale scores and proportion of students categorized as competent/incompetent using 3.5 cut-off point ($n = 302$).

SCCS Subscales	Mean ± SD	Competent (%)	Incompetent (%)
Assessment and implementation of spiritual care	3.79 ± 0.62	66.2	33.8
Professional development and improving the quality of spiritual care	3.85 ± 0.65	74.2	25.8
Personal support and patient counseling	3.82 ± 0.54	68.9	31.1
Referral to professionals	3.88 ± 0.70	73.5	26.5
Communication	4.12 ± 0.61	78.1	21.9
Attitude towards patients' spirituality	4.14 ± 0.60	76.8	23.2
Overall	3.93 ± 0.42	79.5	20.5

3.3. Predictors of Spiritual Care Competence

The predictors of the expatriate nurses' spiritual care competence were examined using a multiple regression analysis. The regression model was statistically significant ($F(16, 285) = 7.64$, $p < 0.001$) and accounted for approximately 41.5% of the variance in spiritual care competence ($R^2 = 0.477$; Adjusted $R^2 = 0.415$). As shown in Table 4, age, educational level, perception on existential spirituality, and personal care were found to be significant predictors of spiritual care competence after controlling

all the other predictor variables as constants. Belonging to the 40–49 age group and having a diploma in nursing decreased spiritual care competence by 0.26 (95% CI = −0.49, −0.03, $p = 0.026$) and 0.40 units (95% CI = −0.56, −0.24, $p < 0.001$), respectively. Furthermore, for every unit increase of scores in the existential spirituality and personal care dimensions, the spiritual care competence score also increased by 0.17 (95% CI = 0.01, 0.33, $p = 0.039$) and 0.21 units (95% CI = 0.09, 0.33, $p = 0.001$), respectively. Hence, enhanced existential spirituality and personal care perceptions improved the spiritual care competence of the nurses to a certain extent.

Table 4. Predictors of spiritual care competence ($n = 302$).

Predictor Variable	β	SE-b	Beta	t	*p*	95% CI
Age (Reference: 23–29 years)						
30–39 years	0.10	0.08	0.11	1.30	0.196	−0.05, 0.26
40–49 years	−0.26	0.11	−0.19	−2.25	0.026 *	−0.49, −0.03
50–60 years	0.06	0.16	0.05	0.36	0.721	−0.26, 0.37
Marital status (Reference: Single)						
Married	−0.01	0.06	−0.01	−0.19	0.849	−0.13, 0.11
Nationality (Reference: Filipino)						
Indians	−0.02	0.06	−0.02	−0.25	0.802	−0.14, 0.11
Educational level (Reference: BSN)						
Associate	−0.40	0.08	−0.38	−4.94	<0.001 ***	−0.56, −0.24
Area of practice (Reference: Non–specialty areas)						
Specialty areas	−0.06	0.06	−0.07	−1.06	0.291	−0.18, 0.05
Clinical experience (Reference: <3 years)						
3–9 years	−0.05	0.09	−0.06	−0.56	0.575	−0.24, 0.13
10–19years	0.05	0.12	0.05	0.40	0.690	−0.19, 0.28
>20 years	−0.06	0.15	−0.04	−0.37	0.713	−0.36, 0.24
Previous spiritual nursing course (Reference: Yes)						
No	0.01	0.08	0.01	0.15	0.882	−0.15, 0.17
Attended spiritual care seminars in the past 12 months (Reference: Yes)						
No	−0.11	0.06	−0.13	−1.85	0.067	−0.23, 0.01
Existential spirituality	0.17	0.08	0.20	2.08	0.039 *	0.01, 0.33
Spiritual care	−0.02	0.08	−0.03	−0.28	0.777	−0.18, 0.14
Religiosity	0.03	0.05	0.05	0.67	0.505	−0.06, 0.13
Personal care	0.21	0.06	0.30	3.44	0.001 **	0.09, 0.33

Note. The overall mean score of the SCCS was the dependent variable. β is the unstandardized coefficients; SE-b is the standard error. * Significant at 0.05 level, ** Significant at 0.01 level, *** Significant at 0.001 level. $R^2 = 0.477$; Adjusted $R^2 = 0.415$.

4. Discussion

This research explored the perceptions of expatriate Christian nurses working in Saudi Arabia on their spirituality and spiritual care competence and its predictors. With regard to their perceived spirituality and spiritual care, results revealed high values on three domains, namely, spiritual care, personal care, and existential spirituality. Thus, the nurses were spiritually minded health care practitioners. This finding indicated their compliance to the international code of ethics of the International Council of International Council of Nurses (2012), in which recognizing the spiritual aspect of care and identifying the provision of spiritual care are two of the obligations of all nurses. Similar results were obtained in earlier studies, which suggested having clearly defined views on the fundamentals of spirituality (Cetinkaya et al. 2013; McSherry and Jamieson 2011). Moreover, the high mean score on the spiritual care area suggested that the respondents acknowledge spiritual care as one of the critical dimensions of holistic care (Wong et al. 2008).

The respondents had poor religiosity, as evidenced by the low mean score in this subscale. A similar finding was reported in previous studies conducted among Muslim and Christian nurses in the Netherlands (Van Leeuwen and Schep-Akkerman 2015) and Iran (Zakaria Kiaei et al. 2015). Nurses recognized that spirituality is not only a concept linked with religion and systems of faith and worship but also a universal concept that is unique to all people (McSherry et al. 2002). However, Cruz et al. (2016a) reported that the religion of Muslim patients is interrelated with their spirituality. Therefore, if for any reason Christian nurses do not regard Muslim religion and spirituality as interrelated, then addressing the needs of Muslim patients is challenging. Almutairi (2015) found that expatriate nurses experience difficulty in attending to the spiritual needs of patients.

The perception of nurses on spirituality and spiritual care is associated with some of their demographic characteristics. Compared with married nurses, the unmarried ones were more aware that spirituality is closely related to existential elements and spiritual and individuality of care. A study conducted in Turkey found similar results in which the focus of married nurses on their clients' requirement of spiritual care and spirituality was lacking (Ozbasaran et al. 2011). This result could be attributed to intense working conditions and responsibilities as mothers and housewives, as dictated by their culture. Furthermore, the finding of Filipino nurses having a clearer view of existential spirituality and spiritual care than Indian nurses could be interpreted as the compliance of Filipino nurses on the Philippine Nurses Association (2003) advocacy on the provision of a spiritual environment and spiritual care as an essential component of nursing care and responsibilities regardless of the patients' religious beliefs. This result further indicated that Filipino Christian nurses were more self-aware and demonstrated a sense of fulfillment in their time connecting with the spirituality of Saudi Muslim patients than nurses of other nationalities. However, this result warrants further investigation. Moreover, nurses with a high educational level presented high scores on existential spirituality, spiritual care, and personal care dimensions. Previous studies have revealed the same outcome (Ozbasaran et al. 2011; Zakaria Kiaei et al. 2015). This finding concurred with the widely accepted view that nursing practice can be continually widened through the acquisition of knowledge, which can influence nurses' perceptions of spirituality and delivery of spiritual care (Zakaria Kiaei et al. 2015).

In terms of the respondents' proficiency in delivering spiritual care for Muslim patients, nurses perceived themselves to be competent in the six spiritual care competency dimensions measured. This result may be accounted for by the nurses' perception that this aspect of care is an essential and integral part of their role and duty. Moreover, nurses extensively accept that attending to the spiritual needs of patients enhances the overall quality of the nursing care they provide (McSherry and Jamieson 2011) despite differences in their religion and culture. Specifically, the participants were found to be highly competent on attitude toward patients' spirituality, referring to the personal factors relevant in providing spiritual care, which matched the findings derived in an earlier study (Van Leeuwen and Schep-Akkerman 2015). This result indicated that the respondents respected the patients' spiritual beliefs, did not force upon them their personal spirituality, and recognized their own limitations in spiritual care. The respondents felt least competent on one of the more specialized areas of spiritual care, namely, assessment and implementation of spiritual care. This finding indicated that the ability of nurses to determine a patient's spiritual needs or problems, as well as planning spiritual care, calls for improvement to render a holistic spiritual care to patients. It also includes areas in written intra- and inter-professional communication of spiritual needs and spiritual care. This finding closely harmonized with the findings obtained from Van Leeuwen and Schep-Akkerman (2015) study in the Netherlands. Moreover, this result may be due to the poor knowledge about Islam and the culture of Muslim patients.

Findings revealed that educational level, perception of existential spirituality, and personal care were significant predictors of the perceived competence of nurses in delivering spiritual care. The participants' level of education appeared to have a positive impact on their ability in providing spiritual care. This result was supported by Zakaria Kiaei et al. (2015), in which nurses with high

educational levels possessed a broad spectrum of nursing knowledge and skills to face the challenges of providing spiritual care. Thus, educational attainment is an important factor that influences the nurses' application of spiritual care.

Similarly, numerous studies have established the importance of the manner by which nurses relate to their spirituality, which serves as a predictor in delivering spiritual care to patients (Van Leeuwen and Schep-Akkerman 2015). Zakaria Kiaei et al. (2015) affirmed that the spirituality of nurses and their knowledge of spiritual nursing care are vital in addressing the spiritual needs of Muslim patients. The positive correlation among existential spirituality, personal care dimensions, and spiritual care competence denoted that the greater the perceptions of nurses on these domains of spirituality, the more capable they were in delivering spiritual care to their patients. This finding confirmed that the nurses' perception of spirituality could directly affect the provision of spiritual care to patients. Furthermore, for Christian nurses caring for Muslim patients, this finding signifies that the dimensions existential spirituality and personal care are critical for these nurses to nurture in order to provide a more competent spiritual care. The existential construct of spirituality involves searching answers to questions about the meaning of life, illness, and death; it may or may not necessitate a belief in a higher being or religion (Davison and Jhangri 2010). On the other hand, personal care relates to the dimension of spirituality dictated by the need to accommodate personalized care (McSherry et al. 2002). Hence, nurses' existential spirituality and their perceptions toward the patient's personal beliefs, values, morals, and relationships are important for nurses to understand and develop in order to provide competent spiritual care to patients with different religious background.

The outcome of the study should be considered within the realm of its limitations, such as the sample not representing male nurses and non-inclusion of other religious affiliations, nationalities, and hospital settings in Saudi Arabia. Future studies should include these groups to achieve a better understanding of the constructs under study. Moreover, causality is difficult to discern with regard to issues affecting the spiritual competence of nurses due to the nature of the study. Succeeding research should utilize a qualitative approach to elucidate the perception of spirituality and experiences in delivering spiritual care for Muslim patients among expatriate nurses.

5. Conclusions

This study assessed the spirituality and spiritual care perceptions and the provision of spiritual care of expatriate Christian nurses in Saudi Arabia. Results showed that the respondents were spiritual-minded health care practitioners. Although the surveyed nurses were Christians, they perceived themselves to be competent in delivering spiritual care for Muslim patients. Moreover, their age, educational level, perception of existential spirituality, and personal care were found to be important factors that influenced their provision of spiritual care. Findings support that Christian nurses' existential spirituality and their perception of personal care are important aspects to consider in providing competent spiritual care to patients with Islamic faith.

This study reported modifiable and nonmodifiable factors influencing Christian nurses' provision of spiritual care for Muslim patients; thus, interventions that can improve the modifiable factors should be facilitated. First, nursing management should include a series of continuing education to its expatriate nursing staff regarding Muslim religion, as well as the cultural beliefs and practices of Saudi and other similar nationalities. Moreover, the spiritual needs of Muslim patients and the manner by which to address them appropriately should be included. This intervention will enhance the understanding of foreign nurses on these related concepts and assist them in the assessment and identification of patient-specific spiritual needs or problems, thereby ensuring the provision of appropriate and competent care. Second, the findings revealed that nurses with a BSN degree had better spirituality and spiritual care perceptions, as well as higher competence in delivering spiritual care. Thus, nursing administrators should prioritize hiring nurses with BSN qualification. Additional spiritual care-related training and seminars should be provided to associate degree nurses to hone better perceptions and ensure high levels of competence in delivering spiritual care. Lastly,

staff nurses should continue to broaden their personal and inward discoveries to enrich their existential spirituality. Nurse administrators should acknowledge the critical role of existential spirituality to the quality of spiritual care rendered to patients with varying religious background.

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