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# Explaining the Experiences of Nurses about Barriers of Religious Care in Hospitalized Patients: A Qualitative Study

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**Abstract**

**Background and Objectives:** The religious needs of hospitalized patients are reportedly not appropriately met. The purpose of this study was to explain the experiences of nurses about the barriers to providing religious care for hospitalized patients.

**Methods:** This qualitative study was conducted on 21 nurses working in a hospital affiliated with Qom University of Medical Sciences, Qom, Iran, in 2017, using the conventional content analysis. Data collection was performed using semi-structured interviews lasting about 60-95 min.

**Results:** The barriers related to the nursing staff included efforts to meet the patient's physical needs, not giving priority to religious care, lack of knowledge and skills, ambiguity in religious care, poor motivation for nursing, routine work, belief that religious care provision is apart from nursing duty, inability in communicating with the patient, lack of holistic care, and belief that religion is personal. In addition, the barriers related to the patient entailed the lack of patient's request for religious care, lack of knowledge about religious care as a part of nursing care, and physical condition. Finally, the management-related barriers pertained to the lack of facilities, including insufficient space, lack of religious books in the departments, lack of sand for Tayammum, lack of a prayer room, not facing the patients toward Qiblah, high workload, crowded wards, and nursing staff shortage.

**Conclusion:** Nurses should consider religious care in hospitals as an important aspect of nursing care and receive necessary instruction on holistic care. Furthermore, nurses interested in this domain should receive support for the delivery of religious care.

**Keywords:** Religion and medicine, Nursing care, Patients, Qualitative research.

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## Introduction

One of the central tasks of nurses is to provide holistic care for patients admitted to hospitals and health care centers (1,2). The receipt of these care services is the basic right and expectation of patients (3, 4). According to the literature, when patients are admitted to the hospital, they need to fulfill their religious needs more than other times; so, they require the treatment team members to help them in this regard (4,5). It is argued that religion satisfies many of peoples' needs and fills the void in them. Religion and religious compliance with difficulties (4,6,7). Religion is an important strategy for the adaptation of individuals to life-threatening illnesses (8), promotion of moral values, enhancement of inpatients' satisfaction and helping them to meet their rights, and reduction of patients' mental health problems (7,9).

In a study conducted on 64 patients with cardiac disease, spiritual/religious programs were demonstrated to be effective in the mitigation of patients' anxiety (10). Additionally, there is evidence regarding the

effectiveness of religious practices, as a sedative factor, in the reduction of anxiety, pain, and depression among patients (11). The literature is indicative of the positive attitudes of nurses towards providing spiritual care in hospitalized patients (7,12,13).

Despite the importance of providing religious care in hospitalized patients, studies show that this kind of care is not well provided and that religious needs of patients are not appropriately met (4,5,8,14). Abedi et al. introduced the individual and environmental factors as the most important barriers to providing spiritual care (4). Emamisigaroudi et al. reported an undesirable status regarding the provision of spiritual care for hospitalized patients in various domains (8).

In a study, Zand and Rafiei highlighted the spiritual care needs of hospitalized patients (15). Karimallahi and Abedi examined the patients' experience of saying prayers in hospitals. They reported that patients faced some problems in this regard after hospital admission. These problems were related to prayer barriers, prayer facilities, and adaptation (16). In addition, Khansanami et al. investigated the barriers to prayer among inpatients and reported that 72% of patients could not perform prayer during their hospital stay (17).

A number of studies have highlighted some other barriers, including the lack of enough room to adjust the patient's bed toward Qiblah, patients' lack of knowledge about and awareness of spiritual care, nurses' belief that providing spiritual care is a sort of inquisition, lack of specific instruction, and absence of clergyman during shift work hours to answer patients' religious questions (4,17,18).

The treatment team members, particularly nurses, should make an effort to maintain religious principles and provide the necessary condition for the implementation of religious practices in order to meet the religious needs of hospitalized patients. Nurses, as the key members of the treatment team, should not only consider patients' physical and psychological conditions, but also respect their religious beliefs and attempt to satisfy their needs in this domain (19).

Hospitalized patients encounter problems in terms of fulfillment of their spiritual needs (15), implementation of religious practices (19), maintenance of confidentiality (5), maintenance of privacy (19), presence of an assistive companions (8), cleaning facilities (or Tahara), and access to religiously informed individuals or religious resources (19). Accordingly, the identification and clarification of the barriers to providing religious care for hospitalized patients would be helpful in the establishment of a holistic nursing care plan and improvement of patient satisfaction (20).

Limited number of studies have investigated the barriers to providing religious care by nurses, which have mostly reported contradictory data. With his background in mind, the present study was conducted to investigate the experiences of nurses concerning the barriers they encounter when providing religious care in hospitalized patients in 2017.

## Methods

This qualitative study was conducted on 21 nurses (i.e., 9 males and 12 females) working in Shahid Beheshti Hospital affiliated with Qom University of Medical Sciences, Qom, Iran, in 2017, using conventional content analysis. Qualitative content analysis is a research approach that helps the researcher interpret the data subjectively and analyze them thematically (11). The study population was selected using purposive sampling technique with maximum variation in terms of gender, number, education level, and occupational experience. Data collection was performed using face to face in-depth semi-structured interviews.

The inclusion criteria were: 1) Islam religion, 2) a minimum of two years of clinical work experience, 3) willingness to participate in the study, and 3) narration of experiences regarding the barriers to providing religious care. The participants who were unwilling to continue participating in the study were excluded from the research.

Prior to the study, the participants were informed about the purpose of the study and

ensured regarding the confidentiality of their identity and data. In order to record the interview data, an informed verbal consent was obtained. The participants were free to leave the interview or narrate their experiences. With prior coordination, interviews were conducted at nurses' workplace during their rest time in order not to disturb the process of nursing care delivery.

The participants' demographic characteristics were recorded during the interview. The interview was initiated with raising questions about the patients' demographic information and provision of religious care for patients, for example "What comes to your mind when it comes to providing religious care for hospitalized patients?" or "What barriers you might face when providing religious care to patients?"

In order to gain a deeper understanding of the concept and encourage the interviewee to give further explanation, the researcher engaged the participants with some probing questions, such as "... Please, further elaborate." or "What do you mean by saying that?". Data collection was continued until data saturation. The interviews lasted around 60-95 min.

The researcher carefully listened to the interviews several times to obtain a deep understanding of the materials. The content analysis of the interview data was performed based on a qualitative approach adopted by Lundman and Graneheim (21). To this end, the researcher transcribed the interviews. The entire text of an interview was considered as a whole, and the semantic units (through the specification of words, sentences, or paragraphs of a statement explaining the barriers to providing religious care for hospitalized patients) were written in a sheet. After coding these units, the results of the interviews (conversion of the semantic units to more general concepts and phrases) were reviewed. Subsequently, the obtained codes were combined based on their similarities and differences, and then another categorization was made.

In order to identify themes and ensure the reliability of codes, categories were reviewed, and themes were then extracted. The subthemes related to barriers to providing religious care emerged after comparing the categories with one another. The trustworthiness of the data were ensured using the Lincoln and Guba's criteria, including credibility, dependability, confirmability, and transferability (22).

In order to enhance the credibility of the study, the researcher spent a long time involving in collecting valid information about the barriers to providing religious care. In addition, the obtained data were member checked by the participants, and they commented on the data. Furthermore, supplementary comments were obtained from experts with nursing PhD. The dependability of the data was increased by means of audit trail strategy. This parameter was confirmed by presenting the results of the research to the reviewer of the approved research project and qualified experts.

To increase the confirmability of the findings, all stages of the research were accurately recorded, and confirmed by a qualified expert in qualitative research. Regarding the transferability of the findings, the researcher attempted to provide the exact quotes of the participants. Furthermore, the researcher provided further explanations about the demographic characteristics of the participants to lay the ground for future researchers to examine the issue in diverse contexts.

## Result

A total of 21 nurses, including 9 males and 12 females, were interviewed. After the careful transcription of the interview data, 475 codes were extracted. The codes were reviewed several times and classified according to their similarities. The data analysis resulted in the emergence of three major themes related to providing religious care barrioers, namely nursing staff-related, patient-related, and management-related barriers.

The barriers related to the nursing staff included efforts to meet the patient's physical needs, not giving priority to religious care, lack of knowledge and skills, ambiguity in religious care, poor motivation for nursing, routine work, belief that religious care provision is

apart from nursing duty, inability in communicating with the patient, lack of holistic care, and the belief that religion is personal.

In addition, the barriers related to the patient entailed the lack of patient's request for religious care, lack of knowledge about religious care as a part of nursing care, and physical condition. Finally, the management-related barriers pertained to the lack of facilities, including insufficient space, lack of religious books in the departments, lack of sand for Tayammum, lack of a prayer room, not facing the patients toward Qiblahh, high workload, crowded sections, and nursing staff shortage (Table 1).

Nursing staff-related barriers

The participants of the study stated that their efforts were mostly targeted toward patients' physical needs. They noted that the provision of religious care for hospitalized patients is not the priority of clinical nurses or part of their routine tasks in the ward. Accordingly, the nurses reported to prioritize taking care of patient's physical needs. In this regard, one of the participants said:

"As a nurse, I try to respond to the needs and requests of the patient. Patients usually raise their physical problems." (Participant No. 11).

The participants remarked that one of the barriers to providing religious care is not the priority of this issue. Accordingly, one of the participants stated:

"I've been a clinical worker for about 10 years. The physical needs of the patient are fulfilled, and the patient's religious needs are not a priority for nurses, and they usually do not pay attention to these issues." (Participant No. 5).

The participants also talked about the lack of adequate education regarding the delivery of religious care to patients. A participant mentioned:

"We never heard of religious care neither during our education, nor afterwards. I don't know anything about this issue." (Participant No. 12)

Likewise, another participant also expressed:

"Religious care is not part of the nurse's duties, I've never heard about religious care, and in our ward, there is nothing like that." (Participant No. 9).

Lack of sufficient skill was also an important barrier to providing religious care. In this regard, one of the participants admitted:

"I personally do not have the experience and expertise in providing religious care to patients. This is not familiar to me." (Participant No. 12)

The participants also expressed remarks about the lack of clear guidelines on religious care. They claimed that religious care was an obscure concept for them; accordingly, one of the nurses stated:

"At all, I do not have a clear idea of what the meaning of religious care is. What should I do to provide religious care?" (Participant No. 8)

The participants also talked about the routinization of nursing duties and the execution of doctor's orders. One of the subjects posited:

"In our ward, work assignment is performed using case method. Take a look at the work assignment plan, there is nothing called religious care, [it entails] only the routine tasks of following doctor's orders and daily work." (Participant No. 2)

The participants believed that one of the barriers to providing religious care for patients was the nurses' low motivation for nursing as one of them acknowledged:

"Many nurses are not motivated or interested in continuing nursing. I myself do my tasks routinely. Our job is routinized, so to speak." (Participant No. 3)

The participants believed that the provision of religious care was not their responsibility. They assumed that they were not qualified for the delivery of such care and that this practice can be better implemented by some other people, such as clergymen and cultural agents. This issue was clearly indicated by a participant:

"I think clergymen would better do this. Nurses cannot do this." (Participant No. 8)

The subjects also discussed weakness in establishing communication with the patients when providing religious care. In this regard, one of the nurses mentioned:

Table 1. Major themes and subthemes of barriers to providing religious care

| Major themes | Subthemes | Remarks |
|---|---|---|
| Nursing staff-related barriers | Efforts to meet the patient's physical needs, not giving priority to religious care, lack of knowledge and skills, ambiguity in religious care, poor motivation for nursing, routine work, belief that religious care provision is apart from nursing duty, inability in communicating with the patient, lack of holistic care, and the belief that religion is personal | "As a nurse, I try to respond to the needs and requests of the patient. Patients usually discuss physical problems."<br>"I've been a clinical worker for about 10 years. The physical needs of the patient is fulfilled, and the patient's religious needs are not a priority for nurses, and they usually do not pay attention to these issues."<br>"We never heard of religious care, neither during our education, nor afterwards. I don't know anything about this issue."<br>"Religious care is not part of the duties of the nurses, I've never heard about religious care, and in our ward, there is nothing like that."<br>"I personally do not have the experience and expertise in providing religious care to patients. This is not familiar to me."<br>"At all, I do not have a clear idea of what the meaning of religious care is. What should I do to provide religious care?"<br>"In our ward, work assignment is performed using case method. Take a look at the work assignment plan, there is nothing called religious care, [it entails] only the routine tasks of following doctor's orders and daily work."<br>"Many nurses are not motivated or interested in continuing nursing. I myself do my tasks routinely. Our job is routinized, so to speak."<br>"I think clergymen would better do this. Nurses cannot do this."<br>"I'm weak in my communication skills. I cannot well communicate with the patient and I'm not comfortable with the patient. I cannot talk to patients very much."<br>"You can ask all the nurses in our ward, everyone will say that nursing denotes giving medication, writing a nursing report, and executing the orders of the doctor. We do nothing else for the patient."<br>"I think that our nurses should not be involved in such issues. Religion is a personal issue; we should not discuss it with the patient." |
| Patient-related barriers | Lack of patient's request for religious care, lack of knowledge about religious care as a part of nursing care, and physical condition | "Patients admitted to the hospital are more likely to seek their own physical needs, and especially their daily problems. They have many difficulties after being hospitalized. They do not talk about religion or their religious needs at all."<br>"During my 10-year of work experience, I have not faced any patient talking about religious care or having a request [in this regard]."<br>"After hospitalization, patients are unaware of the need to receive religious care, and they never ask for it."<br>"Patients, especially in their first days of admission, have many physical problems. Given the physical condition of the patients, it is not possible to discuss or deliver religious care." |
| Management-related barriers | Lack of facilities, including insufficient space, lack of religious books in the departments, lack of sand for ablution, lack of a prayer room, not facing the patients toward Qiblahh, high workload, crowded sections, and nursing staff shortage | "There is no place in our ward to provide religious care. The patients should have access to related resources and books. Space must be available for performing religious practices."<br>"The patients who want to pray in the hospital require Tayammum stone. Patients need a praying room or small area in order to do their religious practices, but usually, there is no such places in the wards. The Qiblah direction must be specified for rooms, and patients' beds must be positioned toward Qiblah. Patients have lots of difficulties in this regard."<br>"We are not able to do our daily work let alone providing religious care. We even sometimes do not have time to have breakfast."<br>"The internal ward is so crowded. There are so many works, and often the routine works are not performed."<br>"All hospital wards have a shortage of human resources, especially nurses. Therefore, nurses have to work overtime. We sometimes cannot perform our main tasks owing to fatigue and exhaustion." |

"I'm weak in my communication skills. I cannot well communicate with the patient and I'm not comfortable with the patient.
I've got no problem in training the patients, but I cannot talk to patients very much." (Participant No. 8).

Lack of a holistic nursing care perspective among nurses was raised as another barrier. According to the participants' statements, the nurses pay attention to the patient's physical condition and do not believe in holistic nursing. Accordingly, one of participants posited:

"You can ask all the nurses in our ward, everyone will say that nursing denotes giving medication, writing a nursing report, and executing the orders of the doctor. We do nothing else for the patient." (Participant No. 11).

Although the nurses did not regard religion as a personal matter, they believed that discussing the religious issues with patients may sound

unpleasant to them and considered as a sort of inquisition.

"I think that our nurses should not be involved in such issues. Religion is a personal issue; we should not discuss it with the patient." (Participant No. 7)

Patient-related barriers

Based on the participants' statements, hospitalized patients do not request for religious care because of their physical condition. In this regard, a participant mentioned:

"Patients admitted to the hospital are more likely to seek their own physical problems, and especially their daily problems. They have many difficulties after being hospitalized. They do not talk about religion or their religious needs at all." (Participant No. 16).

In addition, one of them remarked:

"During my 10-year of work experience, I have not faced any patient talking about religious care or having a request [in this regard]." (Participant No. 13).

The participants also pointed to the patient's lack of awareness of religious care as a part of nursing care. This was clearly mentioned by one of the subjects as follows:

"After hospitalization, patients are unaware of the need to receive religious care, and they never ask for it." (Participant No. 7)

The participants also expressed that one of the barriers to providing religious care was the patient's physical condition and problems. This point was raised by one of the nurses as follows:

"Patients, especially in their first days of admission, have many physical problems. Given the physical condition of the patients, it is not possible to discuss or deliver religious care." (Participant No. 17).

Management-related barriers

According to the participants, one of the barriers to providing religious care was the lack of facilities in hospitals. One of the participants admitted:

There is no place in our ward to provide religious care. The patients should have access to related resources and books. Space must be available for performing religious practices." (Participant No. 19).

The participants also referred to the lack of facilities for cleanliness (i.e., Taharat) and making the necessary preparations before performing the religious practices, such as Tayammum stone. This was evidently indicated by a participant as follows:

The patients who want to pray in the hospital require Tayammum stone. Patients need a praying room or small area in order to do their religious practices, but usually, there is no such places in the wards. The Qiblah direction must be specified in rooms, and patients' beds must be positioned toward Qiblah. Patients have lots of difficulties in this regard." (Participant No. 19).

All of the participants complained about their high workload. They claimed that their job is so tiresome that some days, they have no opportunity to take a seat to rest. One of the participants said:

"We are not able to do our daily work let alone providing religious care. We even sometimes do not have time to have breakfast." (Participant No. 17).

The participants also pointed to crowded sections and high density of patients as a barrier to performing works other than the routine ones. One of them stated:

"The internal ward is so crowded. There are so many works, and often the routine works are not performed." (Participant No. 16)

This was also confirmed by another participant as follows:

"All hospital wards have a shortage of human resources, especially nurses. Therefore, nurses have to work overtime. We sometimes cannot perform our main tasks owing to fatigue and exhaustion." (Participant # 16).

## Discussion

The purpose of this study was to investigate the experiences of nurses regarding the barriers to providing religious care for hospitalized patients. The findings revealed three major barriers, including nursing staff-related, patient-related, and management-related barriers. Studies show that hospitalized patients do not receive spiritual care well, and that nurses encounter many challenges for the provision of such care (4,5,8,14,19).

The participants in the study placed their focus on fulfilling patients' physical and routine needs. The nurses reported that they had no predefined duty regarding the provision of religious care in their day-to-day schedule. In other words, they did not consider themselves obliged to providing religious services. Nurses also noted that the delivery of religious care to patients was not a priority in their work, and that this issue was not considered by the officials of the hospital.

In line with this finding, Abedi et al. introduced the non-priority of patients' spiritual needs compared to their physical needs from nurses' perspectives as an important barrier to providing religious care in hospitalized patients. They also stated that the issue of religious care is not emphasized in hospitals by any of the nursing staff and that the nurses only attended to the fulfillment of the physical needs of patients. In addition, they declared that religious care is not considered in the routine planning of the ward. However, some nurses were reported to provide religious care for hospitalized patients based on their personal interest (4).

According to Heydari and Norouzadeh, quoting Tiew et al., barriers to providing religious care include limited training, negative attitudes toward religious care, nurses' confusion over their role, lack of the required skills and abilities, and avoidance of discussing spiritual issues (19). Hafizi et al. also emphasized the significance of nurses' attitudes towards religion in providing spiritual care for inpatients (12).

In the present study, the nurses did not have sufficient education and skills to provide religious care for hospitalized patients. They asserted that such discussions were not addressed during their education and afterwards; therefore, they were not familiar with this issue. In addition, after initiating their job as a nurse, they did not receive any instructions regarding religious care; consequently, they did not have the necessary skills in this domain.

In the same vein, Abedi et al. reported that nurses' lack of awareness about the types of religious care and their impact on the course of the disease, as well as their inadequate knowledge regarding the way of providing spiritual care, is an important barrier regarding the delivery of such care (4). Furthermore, the impact of training on nurses' perception of religious care was emphasized in another study (23).

Provision of education on the concept of religion and the way of providing religious care can affect the knowledge, attitude, and practice of nurses in this regard. This finding underscores the importance of in-service training for nurses. Therefore, it is recommended to implement theoretical and practical training for nurses.

The participants referred to nurses' weak motivation as one of the barriers to providing religious care. Given the problems of nursing staff, nursing officials should take necessary measures in this regard. The findings of this study showed that nurses are accustomed to their routine work. This has led to the routinization of their work, inducing obstacles to the provision of religious care. Consistent with this finding, Rahnema et al. (2011) concluded that one of the impediment to providing spiritual care to cancer patients was the nursing routine work (24,25).

The participants believed that it was not their duty to deliver religious care and that this is the job of religious authorities. They proposed clergymen as better agents for this purpose. As indicated in the literature, nurses still do not consider themselves responsible for providing religious care. Similar to our results, the assumption of the superiority of a clergyman or a psychologist in providing spiritual care was reported as one of the barriers to delivering such care in another study (26). In a study, the private nature of spirituality and assuming religious care apart from nursing agendas were reported as the barriers to providing spiritual care to inpatients (27). In addition, some nurses questioned the need for nurses to provide spiritual care (4,5,15).

The participants had also difficulty communicating with the patient to provide religious care. Therefore, it is essential to provide them with the necessary training in this regard. In a study performed by Adib and

Saeed Nejad, 56.9% of the participants were unable to communicate with the patients (28).

Since caring is the essence of nursing, nurses are responsible for providing holistic nursing care (19). Religious care should be theoretically and practically integrated within the nursing curricula. Nursing students should be acquainted with these topics during their education. In this study, many participants did not have a holistic view regarding the provision of nursing care for patients. Most of the nursing theories emphasize holistic nursing. In this regard, nurses are expected to consider the patient as a whole and pay attention to all his/her needs (2).

According to the participants, one of the barriers to providing religious care was the belief in the private nature of the religion, which refrained them from discussing it with the patient. They assumed that discussing religious matters is a kind of inquisition, which is considered as an inappropriate manner. Similarly, in another study, religion was considered as a private issue (27).

One of the barriers to providing religious care was the barriers related to patients. Nurses stated that after hospital admission, patients seek to improve their physical problems. Many patients do not pay much attention to their religious needs or ask for help in this regard; as a result, nurses do not care about it. The nurses asserted that many patients are unaware of the fact that receiving religious care is a part of their right and that they should receive religious care at the time of admission. Therefore, the patients did not make any requests to receive religious care.

Likewise, Abedi et al. concluded that one of the barriers to providing religious care is related to patient. In the mentioned study, the significant reasons proposed for the non-implementation of religious care were reported as the non-statement of religious needs by patients, consideration of religion and religious practices as a private issue (assuming it as a type of inquisition), patient's physical condition, hospitalization of a large number of patients in the ward, religious belief disparity among the patients, lack of patients' interest in receiving some religious care, and lack of trust on nurses (4).

Zand and Rafiee asserted that a hospitalized patient has some rights that must be taken into consideration, and that the fulfillment of this right is not dependent on the personal preferences of healthcare providers (15). In another study, the most important needs of the patients were religious ones, which was in sharp need of consideration by members of the treatment team (29). Therefore, it is necessary to inform the patients about their right so that they demand religious care from nurses and treatment team. In other words, patients should consider religious care as a part of nursing care and be aware of this issue during their hospital stay.

One of the important barriers to providing religious care to patients was management-related barriers. The participants pointed to the lack of space for performing religious practices. Regarding this, hospital managers need to devote a space for patient's religious care. Based on the nurses, the hospitals lack religious books; therefore, this issue should be handled by the cultural sector of the hospitals. Inpatients have limitations for ablution; as a result, they need Tayammum stone. Furthermore, there is a need to specify a small space for prayer in the hospital wards. The patient beds should also have the capability to be positioned toward Qiblah direction.

A very high workload was another issue raised by the participants. In this respect, they reported that the large number of patients and crowded wards prevented them from performing works other the routine ones. The shortage of nursing staff for performing the routine work of the ward is one of the barriers that is apparent in most of the hospitals.

Zand and Rafiee reported that the provision of spiritual care was considered essential by hospitalized patients. Therefore, they recommended to the hospital managers to provide spiritual care as part of hospital holistic care (15). Abedi et al. identified several factors accounting for the non-provision of spiritual care in the hospital. These factors included the lack of nurses' motivation due to the absence of support from

the managers and authorities of hospitals, lack of educational courses, failure to create appropriate spaces, and non-allocation of funds for the establishment of facilities for providing spiritual care (4). Regarding this, it is recommended that hospital managers in collaboration with the cultural sector take some measure in this regard.

One limitation of this study is the small sample size that limits the generalizability of the results; therefore, future studies are recommended to use a larger sample size. This study was conducted on the Iranian Muslim nurses; as a result, the findings cannot be generalized to other religions and countries. It is also suggested to further examine each of the themes obtained in this study.

## Conclusion

The results of this study revealed three major barriers to the provision of religious care for hospitalized patients, namely nursing staff-related, patient-related, and management-related barriers. Nursing managers and nurses should consider offering religious care as an important dimension of nursing care. Nurses need to receive the necessary training on providing holistic care and establishing communication with patients. Furthermore, motivated nurses providing religious care should be supported. Additionally, patients admitted to hospitals need to demand religious care from nurses and be aware of their right. Hospital managers and cultural sector should also provide facilities and nursing staff to facilitate the delivery of religious care in hospitals.

## Conflict of interest

The author declares no conflict of interest.

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