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Research Paper

Relationship Between Nurses' Spiritual Care Competence and Family Satisfaction in Critical Care Units

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ABSTRACT

Background and Objectives: Spiritual competence can help patients recover and achieve better health outcomes. This study examines the relationship between nurses' spiritual care competence and family satisfaction of patients admitted to critical care units (CCUs).

Methods: This was a cross-sectional study conducted from July to December 2023. A total of 123 adult critical care nurses and 123 family members of patients were randomly selected from social security hospitals in Tehran City, Iran. Data collection tools included the spiritual care competence scale, nurses' spiritual care competency questionnaire, and family satisfaction in the intensive care unit (ICU) questionnaire. The SPSS software, version 24, was used for data analysis.

Results: The results showed the high competence of spiritual care in critical care nurses (104.60±18.47). The nurses' lowest score of spiritual care competence was in the assessment and implementation (17.90±6.45 out of 30), and the best score was in communication (9.23±1.07 out of 10). The results showed that families had the lowest level of satisfaction in decision-making (48.62±21.23 out of 100), and the highest score was in satisfaction with care (51.60±19.54 out of 100). The findings indicated that the competence of nurses in spiritual care is not correlated to family satisfaction.

Conclusion: The weak correlation between nurses' spiritual care competence and family satisfaction highlights the complexity of factors influencing spiritual well-being in healthcare. The authors suggest further research into the factors affecting nurses' spiritual care competence and the impact of related training on nursing practice quality.

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Introduction

In recent years, the development of new approaches to patient care has highlighted the necessity for an effective and efficient framework aimed at enhancing the quality of services within the healthcare system. In this context, effective care encompasses all aspects of human life and views health as the maintenance of balance among the patient's body, mind, and spirit [1]. According to the American Nursing Association (ANA), providing spiritual care to patients is a fundamental aspect of nursing [2]. This type of care is characterized as a mental, dynamic, interactive, and collaborative approach that represents a distinct form of nursing care [3]. Spiritual care involves assisting individuals who are grappling with their beliefs, values, purpose, and the meaning of life, particularly when they are confronted with serious illnesses. A spiritual caregiver helps the patient achieve a sense of integrity and wholeness by enhancing their spiritual and religious aspects and alleviating spiritual distress, thereby fostering a better connection with a higher power, themselves, and the world [4]. Spiritual care influences the interventions that nurses implement to address the spiritual needs of their patients [3]. Being hospitalized in an intensive care unit (ICU) significantly contributes to the spiritual distress experienced by patients while also placing their families in a state of uncertainty, helplessness, and confusion, leading to high levels of stress. As these patients require constant monitoring and care due to their unstable conditions, their families often receive less attention, resulting in increased tension from the trauma and crisis they are facing. This stress can lead families to struggle with adaptation and provoke intense psychological responses, which can adversely affect the family's well-being and the patient's recovery. Many families are worried about the uncertainty surrounding the disease's outcome, the patient's condition, the stressful environment, the medical equipment, and the fear of what lies ahead [5]. Research shows that providing spiritual comfort to families in these distressing circumstances can significantly alleviate their tension, anxiety and depression [6]. Spirituality has shaped how family members perceive the patient's prognosis and make decisions on their behalf. Consequently, the family's access to spiritual care in the critical care unit (CCU) has provided them with comfort and resilience, alleviating their distress [7]. Recognized as a vital aspect of palliative care, a deeper understanding of spirituality in critical situations, like a patient's stay in the ICU, can enhance nurses' ability to implement effective strategies and support mechanisms that benefit both the patient and their family [8]. The most recent recommendations for family-centered care in the CCU suggest that families should also receive spiritual support. However, there is still a lack of clear direction on how nurses can impact the spiritual well-being of families [9]. Providing spiritual care to both patients and their families can alleviate physical pain, lessen depression and anxiety, speed up recovery, enhance hope, and strengthen the communication between patients and nurses [10]. Focusing on advanced care technologies in critical care can sometimes hinder the provision of holistic patient care and overlook the needs of family members [11]. Research indicates that intensive care nurses face difficulties in delivering spiritual support to family members. These challenges are mainly caused by the lack of clarity of nurses regarding the spiritual care needed by family members [12]. As a result, there has been increased focus on the spiritual competence of nurses in delivering effective spiritual care in recent years [13]. Nursing competencies in spiritual care encompass six key areas as follows: Assessing and providing spiritual care, maintaining professionalism and enhancing the quality of spiritual care, offering personal support and counseling, referring patients to specialists, fostering a positive attitude toward spirituality, and effective communication [14]. Research has been conducted on spiritual care and its impact on family satisfaction [15]. Enhancing the quality of care in the CCU can be accomplished by assessing family satisfaction [16].

Escudero (2014) highlights the importance of organizing compassionate care in the ICU, similar to the need for advanced monitors and ventilators. Such investment is essential to address social needs and improve family satisfaction [17].

Nurses in critical care settings are specially prepared to support families during difficult and stressful times because of their close interaction with patients. In these situations, family members need physical and emotional assistance from nurses [18, 19]. The daily practices in nursing, combined with traditional care methods that focus on the illness, insufficient training programs, vague definitions of spiritual care and limitations in time and staffing, are recognized as obstacles to delivering spiritual care [12]. Accordingly, while the foundational understanding of spiritual care's importance in the ICU context is growing, a critical gap remains in our understanding of its correlation with family satisfaction. Addressing this gap is essential for developing evidence-based research that truly shows the holistic needs of families facing the challenges of a loved one's critical illness. By illuminating the connection between nurses' provision of spiritual

care and family satisfaction, we can pave the way for a more compassionate, responsive and ultimately more effective ICU experience for the families who are an integral part of the patient's journey. Therefore, this study examines the relationship between nurses' ability to provide spiritual care and the satisfaction levels of families with loved ones in CCUs.

Methods

This study was a descriptive-analytical cross-sectional study. The participants included adult ICU nurses from social security hospitals in Tehran City, Iran, as well as first-degree relatives of the patients. Sampling was conducted using a random number table to select eligible nurses from various shifts (morning, evening, and night). Random sampling was conducted among nurses working in adult ICUs (internal ICU, surgical ICU, general ICU, cardiac ICU and CCU) in social security hospitals in Tehran City, Iran, which were selected through convenience sampling method (Ayatollah Kashani, Fayyaz Bakhsh, Labafi and Lavasani). For this purpose, the researcher visited the nursing office of each hospital and received a list of names of nurses working in the ICU and the name of the relevant department, and selected the sample using a random number table. Also, sampling was done in an available manner from among the first-degree family members of the patients according to the inclusion criteria. In this study, only one first-degree family member of the patient participated in the sampling for each patient. The researcher explained the study's process and objectives, addressed any questions or concerns from the participants, and emphasized that participation was entirely voluntary, assuring them of the confidentiality and protection of their information. After obtaining written informed consent, participants received questionnaires. A total of 246 individuals were included in study (nurses=123 and family members=123), as determined by the formula used for correlation studies: N=[(Za+Zb)/C] 2+3, with a 95% confidence level, 80% test power, and assuming that the correlation coefficient between each of the variables of the research is 0.25; accordingly, the relationship between the two variables is considered statistically significant. Data analysis was conducted using descriptive and inferential statistics, including the Pearson correlation coefficient and regression, with the SPSS software, version 24. A $P<0.05$ was considered statistically significant. To be eligible for the study, nurses were required to hold at least a bachelor's degree in nursing, have a minimum of one year of clinical experience in an adult ICU, and be willing to participate in the research. Family members of patients needed to be at least 18 years old, have a first-degree relationship with the patient, be able to read and write, and agree to take part in the study. Both nurses and family members were excluded if they did not complete the questionnaire (>10% of the items) or if they had serious psychological conditions that could impede their participation. The data collection tool included a demographic information datasheet for both nurses and the families of patients, the Persian version of the spiritual care competence scale (SCCS) questionnaire, and the family satisfaction in the ICU-24 (FS-ICU 24) questionnaire, which measures family satisfaction and was completed through self-assessment. The demographic for nurses collected data on age, gender, marital status, education level, job status, work experience, shift, department and whether they had taken spiritual care training. For family members, the information was about their occupation, their relationship to the patient, the length of the patient's hospital stay, their residence and the type of health insurance. The spiritual care competency questionnaire, created by Van Leeuwen (2009), consists of 27 items organized into 6 categories [20]. Assessing and implementing spiritual care (items 1 to 6) refers to the ability to identify spiritual needs and problems and to plan for spiritual care. Professionalism and improving the quality of spiritual care (items 7 to 12) include those activities of nurses that aim to ensure the quality of care and develop policies in the area of spiritual care. Individual support and consultation with the patient (items 13 to 18), which is the heart of spiritual care and is the actual provision and evaluation of spiritual care face-to-face for the patient and their relatives. Referral to specialists (items 19 to 21) involves working with other healthcare professionals and spiritual counselors or trained counselors. Attitude toward the patient's spiritual mood (items 22 to 25) classifies individual factors related to the provision of spiritual care. Communication (items 26 and 27) refers to the interactions between the nurse and the patient. The items are scored based on a 5-point Likert scale with responses from strongly disagree (1 point) to strongly agree (5 points). The range of scores is 27-135. Higher scores indicate higher competence in spiritual care. In Iran, Khalaj et al. (2012) psychometrically evaluated this questionnaire and reported the Cronbach α coefficient of 0.77 [21]. The FS-ICU 24 was designed by Hayatinia et al [18] and has 24 items in two domains as follows: Satisfaction with care (items 1 to 20) and satisfaction with decision-making (items 21 to 24). The items are scored based on a 5-point Likert scale (1 for poor choice and 5 for excellent choice). The total score ranges from 0 to 100 [18]. Also, the Persian version of the FS-ICU-24 was validated by Hayatinia et al. [18]. Meanwhile, the

Cronbach α coefficient for the dimensions and total questionnaire was higher than 0.7 [18].

Results

A total of 124 nurses, aged between 23 and 53 years and with work experience ranging from 1 to 29 years, participated in this study. Most of the participants were female (69.1%), married (61.8%), nursing bachelor's degree (82.8%) and officially employed (77.2%). Among the nurses, 4.9% reported having informal training in spiritual care (Table 1). The ages of family members ranged from 19 to 72 years (36.3±14.2 years), and patients' hospital stays varied from 5 to 90 days (13.97±11.9 days). The majority of families were female (52.8%), married (55.3%), had a diploma education (25.2%), and were employed (36.6%) (Table 2). The mean scores for nurses' competency in spiritual care showed that the assessment and implementation of spiritual care received the lowest score (17.90±6.45 out of 30), while the highest score (9.23±1.07 out of 10) was in communication (Table 3). Families of patients in the CCU reported the least satisfaction (scoring 48.62±21.23 out of 100) regarding decision-making, while the highest satisfaction was related to the care provided, with a score of 51.60±19.54 out of 100. The mean score of satisfaction in the families (51.60±19.16 out of 100) suggests overall positive satisfaction (Table 4).

The results of the linear regression analysis showed that nurses' competence to provide spiritual care does not influence family satisfaction (R^2=0.010, P=0.278; Table 5). Also, the regression analysis showed that the demographic factors of the family of the patients hospitalized in the CCU did not affect their satisfaction (P>0.05) (Table 6).

Discussion

Recent studies indicate that nurses have a notable level of spiritual competence. Nevertheless, their main challenge is assessing and providing spiritual care, whereas their greatest strength is in communication skills. A study conducted by Asgari [22] in Iran, titled "perceived spiritual care competence and its associated factors in nursing students during the COVID-19 pandemic," revealed that nursing students showed a significant level of spiritual care competence. The communication dimension had the most substantial influence on enhancing spiritual care competence, while the specialization and quality improvement dimensions had the least effect [22]. These findings are consistent with those of the current study, which also shows a strong level of spiritual care competence and underscores the significance of the communication domain. Ramadhan (2020) in Indonesia found that ICU nurses had a significantly high level of spiritual competence [23], which is consistent with the findings of the present study. Furthermore, Azarsa (2015) identified communication as the primary challenge faced by nurses, while their strongest spiritual care competence was noted in the areas of evaluation and implementation. These observations also resonate with the findings of the present study regarding both the overall level of spiritual competence and the specific communication dimensions [24]. Seid et al. (2021) in Ethiopia report an average level of spiritual care competence among nurses. Notably, the most challenges were in providing social support, while the strongest performance was in the communication [25]. This finding is consistent with the current study regarding communication; however, discrepancies arise when considering the overall scores and other dimensions, which may be attributed to the specific selection criteria for nurses in the study, as it included only intensive care nurses. Similarly, Riahi et al. (2018) found that the spiritual care competence of intensive care nurses before training was also average, aligning with the attitude dimension of the current research but diverging in other areas and the overall score [26]. The present study suggests a generally positive level of satisfaction among families of ICU patients. In agreement with related studies, Sadin et al. (2021) corroborated the findings regarding satisfaction with care, although the tools used for measurement differed between the two studies [5]. The finding of lower satisfaction in decision-making could also indicate a perceived lack of family involvement in the process. Families often feel powerless and excluded, especially when decisions are perceived as being made unilaterally by the medical team. Furthermore, which aligns with the current study, McLennan et al. (2020) conducted research in Australia that revealed the lowest satisfaction was in participation in the decision-making dimension and the highest in care satisfaction measures [27]. The research conducted by Sabzalizadeh in Iran [28] and Midega in Brazil [29] revealed that the dimension of participation in decision-making received the lowest satisfaction ratings, while the highest ratings were in measures concerning satisfaction with care [28, 29]. Conversely, Lam et al. (2015) reported in their study in Hong Kong that the highest satisfaction was associated with participation in decision-making, while the lowest was linked to satisfaction with care measures [30]. The slightly higher satisfaction with the care provided, while still alarmingly low at just over 50%, suggests a potential disconnect between the perceived technical aspects of nursing care and the holistic needs of fami-

Table 1. Demographic characteristics of critical care nurses in selected social security hospitals in Tehran City, Iran, in 2023

Variables		No. (%)/Mean±SD
Gender	Male	38(38.9)
	Female	85(69.1)
Marriage	Single	47(38.2)
	Married	76±61.8
Education	Bachelor of science in nursing	102±89.9
	Master of science in nursing/PhD	21±17.1
Job status	Contractual	28±22.8
	Official contract	95±77.2
Spiritual care training	No	117±95.1
	Yes	6±4.9
Shift	Fixed	29±23.6
	Rotation	94±76.4
Age (y)	38.63±8.28 (range: 23-53)	
Work experience	15.2±8.4 (range: 1 - 29)	

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

lies. Families may be acknowledging the competence of nurses in providing basic medical and nursing interventions. In this study, the disparity between satisfaction with decision-making and care provided highlights the complex interplay of factors influencing the family experience in the CCU. While families may acknowledge the technical proficiency of nurses, the lack of perceived involvement and communication surrounding critical decisions significantly impacts their overall satisfaction. This underscores the importance of moving beyond a purely biomedical model of care to one that embraces family-centered care, where the family is recognized as an integral part of the patient's care team [31].

Ultimately, the current research indicates that the effectiveness of nurses' spiritual care contributes only a marginal 1% change in the satisfaction levels of families with patients in intensive care. A study conducted by Bangcola et al. (2022) in the Philippines revealed that optimal spiritual well-being necessitates a collaborative effort among the patient, family, and nurse, establishing a triadic relationship [32]. However, this relationship's alignment with family satisfaction in hospitalized patients was not corroborated by the current research. The discrepancy may stem from differences in patient selection; while previous studies included elderly patients from different medical units, the present study focused exclusively on elderly and non-elderly patients receiving intensive care. Furthermore, the earlier study gauged satisfaction primarily through trust in care. Fatemi et al. (2011) identified a significant link between nurses' spirituality and patient satisfaction, noting that nurses' spirituality accounted for a 3% influence on satisfaction levels [33]. In addition, this finding diverges from the current study, likely due to the differing patient populations, as the previous research did not concentrate on ICU patients. Additionally, the correlation observed in that study was notably weak. In the present study, nurses' spiritual competence is not related to the satisfaction of families of patients hospitalized in the ICU. The lack of training for nurses in spiritual care could be a contributing factor that is probably a reason for the lack of correlation between nurses' spiritual competence and family satisfaction. Furthermore, the high level of overall satisfaction reported by the families suggests that other factors, such as communication and empathy, may also play a significant role in family satisfaction. An additional concern that may obscure the connection between nurses' spiritual competence and the satisfaction experienced by families is the psychological and emotional

Table 2. Demographic characteristics of families of patients admitted to the CCU of selected social security hospitals in Tehran City, Iran, in 2023

Variables		No. (%)
Sex	Male	58(47.2)
	Female	65(52.8)
Marital status	Single	55(44.7)
	Married	68(55.3)
Education	Under diploma	38(30.9)
	Diploma	54(43.9)
	University education	31(25.2)
Job	Unemployed	16(13)
	Employed	45(36.6)
	Retired	12(9.8)
	Housekeeper	32(26)
	Student	18(14.6)
Type of kinship (with the patient)	Spouse	30(24.3)
	Father or mother	21(17.1)
	Brother or sister	21(17.1)
	Child	51(41.5)
Residence	Outside the city where the hospital is located	20(16.3)
	In the city where the hospital is located	103(83.7)
Health insurance	No	12(9.8)
	Yes	111(90.2)

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Qom University of Medical Sciences

Table 3. Spiritual care competency of critical care nurses in selected social security hospitals in Tehran City, Iran, in 2023

Domain	Mean±SD	Minimum	Maximum
Assessment and implementation of spiritual care	17.90±6.45	6	30
Specialization and improving the quality of spiritual care	21.76±5.53	6	30
Personal social support	24.82±4.64	10	30
Referral to specialists	12.59±2.46	6	15
Attitudes about patient spirituality	18.33±2.26	8	20
Communications	9.23±1.07	4	10
Total spiritual care competency score	104.60±18.47	49	135

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Qom University of Medical Sciences

Table 4. Satisfaction of families of patients admitted to the CCU of selected social security hospitals in Tehran City, Iran, in 2023

Domain			Mean±SD	Minimum	Maximum
Satisfaction with care (out of 100)			53.83±19.54	0	100
Satisfaction with decision-making (out of 100)			48.62±21.23	0	100
Total satisfaction score (out of 100)			51.60±19.16	0	100
Satisfaction	Very weak (0-25)	Weak (25-50)	Good (50-75)	Very good (75-100)	
No. (%)	3(2.4)	55(44.7)	46(37.4)	17(13.8)	

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Qom University of Medical Sciences

turmoil faced by family members during the hospitalization of a critically ill patient. Subsequent studies could investigate the impact of these dynamics. The lack of a statistically significant relationship between nurses' spiritual care competence and family satisfaction challenges the intuitive assumption that more competent spiritual care directly translates to greater satisfaction among families in the stressful environment of the CCU. This finding diverges from studies conducted in other contexts that have often demonstrated a positive association between these variables. For example, a study demonstrated a positive association between spiritual care and family satisfaction [34]. The finding that nurse spiritual care competence does not consistently correlate with FS-ICU necessitates a critical examination of the underlying reasons. Several potential explanations can be explored. Spiritual care is a deeply personal and subjective experience, encompassing a broad range of beliefs, values, and practices. Competence in spiritual care, while encompassing knowledge and skills in assessment and intervention, also requires empathy, sensitivity, and a genuine willingness to engage with the individual's unique spiritual perspectives [35]. What constitutes effective spiritual care for one family may differ significantly from another, influenced by their cultural background, religious beliefs, personal experiences, and coping mechanisms [36]. Therefore, even a highly competent nurse delivering what they perceive as appropriate spiritual care may not resonate with a particular family's specific needs or expectations, leading to a disconnect between competence and satisfaction.

Study Limitations

One limitation of this study is the low percentage of nurses with spiritual care training or cultural factors that may influence family satisfaction.

Conclusion

The results of this investigation suggest that the spiritual care competence of nurses exhibits a weak correlation with the satisfaction of patients' families. This finding is not necessarily a reflection of inadequate care, but rather a testament to the subjective nature of spiritual needs and the multifaceted dynamics of families facing illness. Despite the positive nature of nurses' spiritual care competence, it is imperative for nurses, as integral members of the intensive care and treatment teams, to enhance their understanding of the spiritual needs of both patients and their families. By improving their spiritual care competence, nurses can deliver more holistic nursing care. Implementing training workshops focused on this area could be beneficial. The study identified that nurses' competency in communication is high, but their competency in the assessment and implementation of spiritual care is low. Therefore, there is a need to provide training programs for nurses to enhance their competence in assessing and implementing spiritual care. The results

Table 5. Relationship between nurses' spiritual care and family satisfaction in Tehran CCUs, 2023

Variables	Reference	Category	Non-standard Coefficient	Standard Coefficient	P
Spiritual care competence	Satisfaction	-	-0.10	0.09	0.278
Summary of linear regression model		R^2=0.01			

Note: Percentage variability=R^2×100=0.01×100=1

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Qom University of Medical Sciences

Table 6. Relationship between demographic factors and satisfaction of families of patients admitted to the ICU in Tehran City in Iran 2023

Variables	Category	Reference	Unstandardized Coefficient (β)	Standard Deviation	P
Gender	Male	Female	-1.33	3.47	0.703
-		-	0.04	0.12	0.707
Marital status	Married	Single	2.03	3.48	0.560
Education	Under diploma	Academic	1.07	4.66	0.819
	Diploma	Academic	3.58	4.34	0.411
Job	Employed	Unemployed	-1.28	5.57	0.819
	Housewife	Unemployed	-2.12	7.31	0.772
	Retired	Unemployed	6.44	5.86	0.274
	Student	Unemployed	4.99	6.58	0.450
Type of relationship with the patient	Father or mother	Spouse (husband and wife)	2.33	5.51	0.673
	Sister or brother	Spouse	-0.54	5.51	0.921
	Child	Spouse	0.61	4.46	0.891
Length of stay (d)	-	-	0.04	0.14	0.749
Health insurance	Yes	No	-8.23	5.80	0.158

Health, Spirituality and Medical Ethics Journal
Qom University of Medical Sciences

of this study have several implications for nursing practice and education. Nurses' spiritual care competence is a critical component of comprehensive patient care, and healthcare organizations should prioritize providing adequate education and training in this area. The development and implementation of evidence-based spiritual care programs can increase nurses' competence and confidence in providing spiritual care to patients and their families. Spiritual needs should be incorporated into individualized care plans, recognizing that each patient and family will have unique spiritual requirements. A flexible approach, rather than a standardized protocol, is essential. Finding has implications for teamwork in which fostering a culture of interprofessional collaboration, where nurses work closely with chaplains, social workers, and other healthcare professionals to address the holistic needs of patients and families. Also, healthcare organizations must dedicate adequate resources to the training, implementation, and staffing of spiritual care programs. This includes time allocation and budget. Healthcare institutions can move beyond simply acknowledging the importance of spiritual care to actively and effectively integrating it into the fabric of ICU practice. This will not only enhance the holistic care provided to patients and their families but also foster a more compassionate and humanistic ICU environment, better equipped to meet the profound spiritual challenges inherent in critical illness. In addition, further research is needed to explore factors that contribute to family satisfaction in critical care settings. Also, it is recommended to analyze the factors affecting the competency of nurses' spiritual care through longitudinal studies or qualitative approaches that investigate the perceptions of family members and nurses about spiritual care more deeply.

Ethical Considerations

Compliance with ethical guidelines

This article is based on research approved by the Medical Ethics Committee of Shahed University, Tehran, Iran (Code: IR.SHAHED.REC.1402.063).

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Authors' contributions

Conceptualization, supervision, and data analysis: Reza Norouzadeh, and Masoumeh Heidari; Methodology: Fatemeh Mohebbi, Reza Norouzadeh, and Masoumeh Heidari; Data collection and writing the original draft: Reza Norouzadeh, Masoumeh Heidari, and Fatemeh Mohebbi; Review and editing: Fatemeh Mohebbi, and Reza Norouzadeh; Final approval: All authors.

Conflict of interest

The authors declared that they have no conflicts of interest.

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