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DISTRESS IN PALLIATIVE COPD PATIENTS IN THE WATES REGIONAL HOSPITAL

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ABSTRACT

Introduction: Chronic Obstructive Pulmonary Disease (COPD) is a group of progressive pulmonary disorders characterized by airflow limitation in the respiratory tract. This study aims to implement nursing care for a palliative COPD patient experiencing spiritual distress at Wates Regional Hospital. This research utilized an observational case study design with a cross-sectional approach. The subject of this case study was a 53-year-old male patient, Mr. S, hospitalized at Wates Regional Hospital. The patient's palliative care screening score was 6, indicating the need for referral to palliative services. The Edmonton Symptom Assessment System (ESAS) revealed that the most prominent issue was spiritual distress, rated at a level of 7. The patient's Karnofsky Performance Status score was 50%, indicating frequent need for assistance and regular medical care. The Spiritual Well-Being Scale (SWBS) yielded a total score of 41, suggesting a moderate level of spiritual well-being. Spiritual assessment indicated that the patient refrained from performing prayers during illness, believing that illness justified this decision. Based on the assessment, Mr. S was identified as experiencing spiritual distress associated with his medical diagnosis of COPD. The primary nursing diagnosis was spiritual distress related to lifestyle changes, based on the Indonesian Nursing Diagnosis Standard (SDKI). The expected nursing outcomes, according to the Indonesian Nursing Outcomes Standard (SLKI), were improvements in spiritual status, particularly the ability to engage in worship and enhanced coping abilities. Interventions were provided based on the Indonesian Nursing Intervention Standard (SIKI), focusing on supporting the patient's ability to perform religious practices.

Keywords: COPD; Palliative Care; Spiritual Distress

Background

According to the Indonesian Ministry of Health (Kemenkes, 2023), Chronic Obstructive Pulmonary Disease (COPD) is a group of progressive pulmonary diseases characterized by airflow limitation in the respiratory tract, primarily caused by exposure to irritating particles that trigger pulmonary inflammation. The airflow limitation in COPD results from a progressive obstruction of the airways, which impedes breathing and is associated with an inflammatory response in the lungs to toxic and harmful gases or particles. This condition is generally irreversible or only partially reversible. COPD is a systemic disease that involves metabolic, skeletal muscle, and genetic-molecular components. A major complaint among COPD patients is limited physical activity, which significantly affects their quality of life. Skeletal muscle dysfunction plays a key role in this limitation. Systemic manifestations of COPD include systemic inflammation, weight loss, increased risk of cardiovascular disease, osteoporosis, and depression.

One of the most common symptoms experienced by COPD patients is shortness of breath, which often becomes the primary complaint. This dyspnea typically occurs during physical activity and becomes more severe when the Forced Expiratory Volume in 1 second (FEV1) falls below 60% of the predicted value (E. Sari et al., 2024). Dyspnea may be perceived as increased effort to breathe, a feeling of heaviness while breathing, or even an overwhelming “air hunger.” In addition to shortness of breath, chronic cough is also a common symptom among COPD patients. This cough may be intermittent but is often an early sign of disease progression. In some cases, the chronic cough may occur without sputum production, making it difficult to detect in its early stages. As the disease progresses, patients may experience additional symptoms such as wheezing, pulmonary hyperinflation (often observed as a "barrel chest"), and other chronic signs such as weight loss and muscle wasting (Simbolon, 2020).

COPD has a substantial impact on patients’ quality of life. One of the most significant effects is physical limitation. Patients frequently experience chronic dyspnea, which impairs their ability to

carry out daily activities, including work and social interactions. This can be particularly detrimental for patients who are still in their productive age, as they may feel unable to function optimally (Asyrofy et al., 2021). COPD is also a major public health concern in Indonesia. Data indicate that COPD ranks as the fourth leading cause of death nationwide, with a morbidity rate of 35%. The prevalence is expected to rise in line with population growth and continued exposure to risk factors such as air pollution and smoking. Globally, COPD remains a significant health issue, contributing to more than 3 million deaths annually, and is projected to be the third leading cause of death worldwide by 2020 (Kurniyanti et al., 2023).

According to Kurniawan (2024), spiritual issues are frequently encountered in patients with COPD, manifesting as spiritual distress that can profoundly affect their quality of life. These patients not only face physical discomfort due to their symptoms but also experience considerable emotional and spiritual burden. This distress may arise from various factors, including loss of hope for the future, reduced ability to perform daily tasks, and a sense of isolation. Spiritual distress may be expressed through existential questions such as “What is the meaning of my life?” In some cases, patients' spiritual beliefs or religious practices may be disrupted, leading to feelings of loneliness and helplessness. Interventions to address spiritual issues include meditation, counseling, and faith-based support tailored to the patient's beliefs. These approaches aim to provide emotional support and help patients rediscover meaning and purpose in life despite facing a serious illness.

Methods

This research utilized an observational case study design with a cross-sectional approach. The study subject was a patient diagnosed with COPD and admitted to the Dahlia Ward of Wates Regional Hospital. Data collection involved both primary and secondary sources.

Primary data were obtained through direct observation of the patient, including general condition, level of consciousness, vital signs, and physical examination. The physical examination followed a systematic approach (Yulaika, 2021) and included: Inspection: Utilizing visual, auditory, and olfactory senses to assess physical signs. Palpation: Using hands and fingers to evaluate characteristics of tissues or organs such as temperature, elasticity, size, moisture, and protrusion. Percussion: Tapping body surfaces to generate sounds that help determine the density, location, and position of underlying structures. Auscultation: Listening to sounds produced by various body organs and tissues. Secondary data were collected from indirect sources, including medical records and laboratory results.

Data analysis was performed through data reduction, which began at the point of data collection. This process included summarizing, coding, identifying themes, clustering data, and writing memos to exclude irrelevant information. Data reduction focused on interview results with the COPD patient as the subject. The data presentation took the form of narrative text based on interview notes with both the patient and their family, as well as observational and physical examination findings in the Dahlia Ward’s isolation room at Wates Regional Hospital.

The conclusions were drawn by identifying characteristics and contributing factors of the patient's condition. Thus, data analysis was a continuous and cyclic process that involved interaction between data reduction, presentation, and conclusion drawing until the research process was complete. In line with the research design, the analytical method employed in this study was descriptive. Data were systematically organized using interview guides, nursing care formats, and literature sources. Verification was conducted by reviewing the data reduction and presentation processes.

Results

Table 1. Assessment Data

Assessment Data		
Demographics		
	Age	53 Years
	Gender	Male
	Occupation	Farmer
	Religion	Islam
Chief Complaint	Mr. S expressed reluctance to perform prayers during illness, believing that abstaining from prayer was a way to respect the condition of being unwell	
Vital Signs	Respiratory rate: 19 breaths/min; Oxygen saturation: 98% with 3 LPM nasal cannula.	
Respiratory System	Airway narrowing indicated by decreased FEV1 values.	
Medical Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)	
Palliative Screening		
	Underlying Disease	2 (COPD)
	Comorbid Condition	1 (Pulmonary Tuberculosis)
	Functional Status	2 (Requires limited self-care, mostly bedridden or in a wheelchair)
	Other Criteria	1 (Spiritual Condition)
	Total Score	6 (Requires Palliative Care)
ESAS (Edmonton Symptom Assessment Scale)		
	Feeling Unwell	5
	Anxiety	3
	Shortness of Breath	5
	Spiritual Distress	7
Karnofsky Performance Scale	50% - Requires considerable assistance and frequent medical care	
SWBS (Spiritual Well Being Scale)	Total score: 41 (Moderate spiritual well-being)	
Diagnostic Test	Spirometry showed a decrease in FEV1 value	
Pharmacological Therapy	Lansoprazole (once daily), Ceftriaxone 1g (every 12 hours), Methylprednisolone 125mg (every 8 hours), Paracetamol 1g (every 8 hours), Combivent inhaler (every 8 hours), Acetylcysteine (every 8 hours), Azithromycin (once daily), OAT 4FDL for COPD (3 tablets/day), Vitamin B6 (once daily), Candesartan (every 8 hours as needed for hypertension), Folic acid (every 12 hours), Nocid (every 8 hours), Bromhexine drip (every 8 hours for mucus reduction)	

Table 1 presents the nursing assessment results, incorporating both primary and secondary data, including patient identity, chief complaints, vital signs, respiratory status, medical diagnosis, palliative care screening, ESAS, physical activity, spiritual well-being, diagnostic testing, and pharmacological management.

Table 2. Nursing Care

Nursing Problem	Spiritual Distress
Nursing Interventions	Implementation of spiritual support (I.09262), including the following planned actions: identify the patient's needs for performing religious practices in accordance with their faith; provide a safe and comfortable environment for worship; facilitate the use of religion as a coping resource; consult with the medical team regarding religious practices requiring special considerations.
Nursing Implementation	Assessment of the patient's spiritual needs included providing clean blankets or pillows for *tayammum* (dry ablution) and religious education, as the patient was unfamiliar with how to perform *tayammum* and prayer during illness. The nurse assessed the patient's willingness to receive spiritual guidance, taught the patient how to perform *tayammum* and prayer in the context of illness, and provided the necessary religious equipment. These interventions were implemented over a three-day period.

Nursing Evaluation	After 72 hours of intervention, the spiritual distress nursing problem was resolved. Significant improvements were observed in the patient's spiritual status, reflected in both subjective and objective outcomes. Initially, the patient exhibited confusion and reluctance to perform prayers due to physical illness and emotional distress. This was accompanied by feelings of hopelessness and existential uncertainty. However, with continuous support, the patient showed a shift in perspective, gaining a renewed sense of meaning and engagement in spiritual activities. The patient's ability to perform religious practices improved from a score of 2 to 5, and coping ability increased from a score of 3 to 5. Subjectively, the patient expressed happiness in acquiring religious knowledge and the ability to perform *tayammum* and prayer while ill. Objectively, the patient demonstrated enthusiasm in performing *tayammum*, and the family actively assisted in the process.

Table 2 presents the nursing care process, encompassing the identified nursing problem, planned interventions, implementation strategies, and evaluation outcomes.

Discussion

Spiritual distress is defined as a disruption in one's belief system or values, manifesting as difficulty in experiencing meaning and purpose in life through connections with oneself, others, the environment, or a higher power (SDKI, 2021). It refers to a state in which individuals experience discomfort or difficulty related to the spiritual dimension of their lives. This may occur when individuals feel a loss of meaning, purpose, or connection with something greater than themselves—such as God, nature, or community (Ningsih, 2024).

In the case of Mr. S, data revealed that the patient's family reported his reluctance to perform the five daily prayers since falling ill, despite his previous habit of praying in congregation with his family at home. Based on the Spiritual Well-Being Scale (SWBS), the patient scored a total of 41, indicating a moderate level of spiritual well-being. During the spiritual assessment interview, the patient appeared resistant, stating that he refrained from praying out of respect for his illness. Further inquiry revealed that he was unfamiliar with the methods of performing *tayammum* and prayer in a state of illness.

For many patients—particularly those of the Islamic faith—religious practice is not only a religious obligation but also a vital source of strength and comfort during periods of suffering. Illness often distances individuals from their daily routines, including regular worship. However, in Islam, worship remains essential, even during sickness. The religion allows adaptations so that individuals may perform rituals according to their capacity (Rahma et al., 2024).

In this context, the role of nurses and healthcare providers is crucial. They are responsible not only for the patient's physical health but also for attending to their spiritual needs. Support may include reminding patients of prayer times, provide prayer equipment, and assisting in religious practices. Such interventions help promote peace and hope, allowing patients to reconnect with their spirituality and draw strength from their faith. Worship becomes a means to express gratitude and find solace, even in adversity.

The planning, implementation, and evaluation of spiritual care interventions are critical in improving the spiritual dimension for palliative patients, as spiritual care is integral to enhancing their quality of life. While the primary focus of palliative care is on relieving pain and managing symptoms, spiritual needs—often overlooked—must also be addressed (Husaeni & Haris, 2020).

The environment in which care is delivered must also support spiritual well-being. Quiet and peaceful surroundings, along with opportunities for reflection or worship, can help patients feel more comfortable and connected to their inner selves and beliefs. By integrating spiritual care into palliative care practices, healthcare providers not only address physical discomfort but also offer emotional and

spiritual support, ultimately contributing to a more holistic care experience. In doing so, patients feel valued and heard during their end-of-life journey.

The nursing interventions applied in this case were based on the Indonesian Nursing Intervention Standards (SIKI, 2022)—specifically, *Spiritual Support for Religious Practices* (I.09262). The planned actions included identifying the patient's needs for religious practice, providing safe and comfortable facilities for worship, facilitating religious practice as a coping mechanism, and coordinating with the medical team regarding any limitations or special considerations.

Assessment findings guided the interventions, with a primary focus on identifying religious needs and providing resources, particularly Islamic education concerning religious practices during illness. Enhancing spiritual awareness and Islamic religious education—especially related to worship—plays a significant role in the care of palliative patients, who often experience emotional and psychological distress due to terminal illness (Ardiyanti & Suprayitno, 2021).

By strengthening spirituality and religious knowledge, patients receive not only physical support but also comprehensive emotional and spiritual care. This helps them find meaning in life, even under difficult circumstances, and fosters hope and resilience. Hence, attention to spiritual care and religious education is an integral component of high-quality palliative care.

Research by Parasyanti et al. (2020) emphasized the vital role of spiritual enhancement in the care of palliative patients, especially as they approach the end of life. In such situations, spiritual support helps them cope with fear, anxiety, and feelings of loss. Similarly, Putri (2020) found that improved spirituality had a positive impact not only on psychological aspects but also on the patient's overall quality of life. Patients who feel their spiritual needs are met tend to experience inner peace and strength, enabling them to better endure their suffering. Spiritual support, therefore, enables patients to find meaning and purpose—even in the midst of terminal illness.

The implemented nursing interventions to address Mr. S's spiritual distress included: assessing his religious needs; evaluating his willingness to receive spiritual guidance; teaching him how to perform *tayammum* and prayer in a state of illness; and providing the necessary worship items. These interventions were carried out over three consecutive days. By the third day, the patient was able to perform *tayammum* independently and pray while sitting semi-upright in bed.

Prior to the intervention, the patient received education on the importance of spirituality in palliative care. He was informed of the benefits of prayer and *tayammum*, and how these practices could help bring peace amid health challenges. The education session included direct demonstrations, allowing the patient to practice alongside the nurse.

The patient's family was actively involved in the process. They were educated on the importance of spiritual support and how to assist the patient in performing *tayammum* and prayer. Family involvement was expected to strengthen the patient's motivation and foster a more supportive environment. This aligns with findings by Sari et al. (2024), which demonstrate that teaching *tayammum* and prayer to palliative patients significantly improves their quality of life. In palliative settings, where the focus is on reducing suffering and enhancing life quality, spiritual care becomes inseparable from holistic treatment. Teaching worship practices not only fulfills religious duties but also promotes inner harmony, helping patients face end-of-life experiences with greater peace and meaning.

The nursing evaluation in Mr. S's case indicated that after 72 hours of intervention, the spiritual distress was resolved. The patient's ability to perform religious practices improved from a scale of 2 to 5, and coping ability increased from 3 to 5. Subjectively, the patient expressed happiness at gaining religious knowledge and being able to perform *tayammum* and prayer despite his illness. Objectively, the patient displayed enthusiasm in performing *tayammum*, and the family actively participated in supporting his practices.

On the first day, the problem was not yet resolved due to the ongoing exploration of the spiritual issue. The patient initially refused to pray, stating it was out of respect for his illness. Upon further questioning, he admitted not knowing how to perform *tayammum* and prayer in such a condition. Consequently, a spiritual education session was scheduled for the second day. By then, the patient was able to follow the *tayammum* ritual with assistance from his family. He stated his intention to pray despite being ill, now that he understood how to do so. By the third day, the issue was resolved—the patient performed *tayammum* with minimal help and completed prayers while seated upright in bed.

The final evaluation demonstrated an improvement in the patient's quality of life through the implementation of *tayammum* and prayer. It can be concluded that spiritual activities not only fulfill religious obligations but also play a significant role in reducing distress and enhancing life quality during the final stages of life. Continued support from religious communities and spiritual counseling is recommended to ensure that patients' spiritual needs are met until the end of life.

Conclusion

Based on the data analysis and discussion in the case report titled *"Case Report on Spiritual Distress in a Palliative Care Patient with COPD in the Dahlia Ward of Wates General Hospital,"* it can be concluded that the nursing assessment of Mr. S revealed a reluctance to perform daily prayers during illness. This behavior stemmed from the patient's belief that refraining from prayer was a form of respect for his condition. Palliative care screening showed the following scores: primary disease (COPD) = 2, comorbid condition (pulmonary tuberculosis) = 1, functional status = 2 (indicating the patient was largely confined to bed or a wheelchair but could perform limited self-care), and spiritual concerns = 1. Thus, the total palliative screening score was 6, suggesting the patient required referral to palliative care services.

The Edmonton Symptom Assessment System (ESAS) revealed that the patient rated his well-being as poor (score 5), reported anxiety (score 3), dyspnea (score 5), and spiritual distress (score 7). The Karnofsky Performance Status score was 50%, indicating the patient often required assistance and frequent medical care. The Spiritual Well-Being Scale (SWBS) score was 41, indicating a moderate level of spiritual well-being.

The nursing diagnosis in this case focused on spiritual distress related to changes in lifestyle, in accordance with the *Indonesian Standard Nursing Diagnosis (SDKI)*. The selected intervention followed the *Indonesian Nursing Intervention Standards (SIKI)*, specifically Support for Religious Practices. After three consecutive days of nursing intervention, the patient's spiritual distress was resolved.

In the context of patients experiencing spiritual distress, appropriate nursing interventions can significantly improve their spiritual well-being. One of the expected outcomes is an increased level of spirituality, which can be reflected through enhanced feelings of peace, hope, and a deeper sense of life's meaning. In this case, the intervention involved providing religious support by teaching the patient how to perform *tayammum* (dry ablution) and prayer in a state of illness.

Following the implementation of this intervention, the patient reported a positive change in his spiritual condition. He experienced greater tranquility, renewed hope, and a deeper sense of purpose. This improvement demonstrates that religious support not only aids patients in practicing their faith but also contributes meaningfully to their mental and emotional well-being.

Thus, the improved spiritual well-being of the patient serves as a key indicator of the intervention's success in alleviating spiritual distress. This underscores the importance of a holistic approach in patient care, where spiritual aspects are recognized and valued as integral to overall health and well-being. The intervention not only provided practical religious guidance but also helped the patient rediscover meaning and purpose in life, even amid significant health challenges.

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