

## Accepted

The screenshot shows a Gmail interface with a search bar at the top. The email subject is "Accepted [BaliMedJ] [Manuscript ID: 3779]". The sender is "Editor Bali Medical Journal". The email content includes:

Dear Authors

We would like to inform you that the revised version of manuscript ID: 3779 has been well received.

Final Decision: **Accepted**

With this email attached several documents from your submitted article entitled "Spiritual care on quality of life patients exposed to COVID-19 in the city area of Semarang"

- Plagiarism reports of the original manuscript
- Final edited manuscript
- Editor Commentary

The plagiarism reports of your original manuscript are 17%, which has already fulfilled the originality criteria.

Our editor has fixed some sections in your manuscript according to the reviewer's suggestion. Please let us know if you are already satisfied with the current final revised manuscript. If you approve this manuscript, your article will be processed for the galley version and published in Bali Medical Journal.

Please return the revised manuscript within 3 days (October 12th, 2022), and type the revision on the attached manuscript below.

Inaccuracy in sending the revised manuscript will affect the time of publication. We're looking forward to your progress, congratulations and good luck.

Best Regards  
Editorial Team

Bali Medical Journal (BaliMedJ)

At the bottom of the screenshot, a taskbar shows three PDF files: "3779-BMJ-Turnitin...pdf", "3779-BMJ-Comme...pdf", and "3779-BMJ-Final E...doc". The system tray shows a temperature of 30°C and the date 08/04/2023.

## Proofreading

The screenshot shows a Gmail interface with a search bar containing "editorbalimedicaljournal@gmail.com". The email subject is "Automatic Reply: Letter of Acceptance". The sender is "Editor Bali Medical Journal". The email content includes:

Automatic Reply: Letter of Acceptance  
This email and any attachments are confidential and may also be privileged. If you are not the intended recipient, please delete all copies and notify the sender immediately.

One attachment - Scanned by Gmail

3779 Tri Hartiti.do...

Below this is an email from "Tri Hartiti" dated "Mon, Feb 13, 11:55 AM":

Dear Editorial Team of Bali Medical Journal Thank you very much for the accepted status of our manuscript. However, the title published was not correct. In the

Below this is an email from "Editor Bali Medical Journal" dated "Mon, Feb 13, 1:36 PM":

Dear authors,

Thank you for your correction. We will revise the title immediately and upload it on Thursday at the latest.

Best wishes,  
Executive Editor BaliMedJ

At the bottom of the screenshot, a taskbar shows a temperature of 30°C and the date 08/04/2023.

**Commentary**

Dear Sir/Madam,

Here are some commentaries to the manuscript entitled *“Spiritual care on quality of life patients exposed to COVID-19 in the city area of Semarang.”*

No.	Section	Commentary
A	Title and Affiliation	<ol style="list-style-type: none"> <li>1. <b>Please write the title in Sentence case</b> → has edited by BMJ editor</li> <li>2. <b>Based on the author guidelines, please write the article in 14 pt TNR font and 1,5 spacing</b> → has edited by BMJ editor</li> <li>3. <b>Please write the author's correspondence and email</b> → has edited by BMJ editor</li> </ol>
B	Abstract	<ol style="list-style-type: none"> <li>1. <b>Based on the author guidelines, please write the article in 12 pt TNR font and 1 spacing</b> → has edited by BMJ editor</li> <li>2. <b>Based on the author guidelines, please write the abstract into for parts namely Introduction, Methods, Results, Conclusions</b> → has edited by BMJ editor</li> <li>3. <b>Please write the scientific name in italics and the second word in lowercase</b> → has edited by BMJ editor</li> <li>4. <b>Please write the keywords in English and without using brackets in sentence case</b> → has edited by BMJ editor</li> </ol>
C	Introduction	<ol style="list-style-type: none"> <li>1. <b>Based on the author guidelines, please write the article in 12 pt TNR font and 1,5 spacing</b> → has edited by BMJ editor</li> <li>2. <b>Please write “INTRODUCTION”</b> → has edited by BMJ editor</li> </ol>



D	Method	<ol style="list-style-type: none"> <li>1. <b>Please write Materials and Methods to METHODS →</b> has edited by BMJ editor</li> <li>2. <b>The method is divided into some parts →</b> has edited by BMJ editor</li> </ol>
E	Result	<ol style="list-style-type: none"> <li>1. <b>Based on the author guidelines, please write the article in 12 pt TNR font and 1,5 spacing →</b> has edited by BMJ editor</li> <li>2. <b>Please write Result to RESULTS →</b> has edited by BMJ editor</li> </ol>
F	Discussion	<ol style="list-style-type: none"> <li>1. <b>Based on the author guidelines, please write the article in 12 pt TNR font and 1,5 spacing →</b> has edited by BMJ editor.</li> <li>2. <b>Please write Discussion to DISCUSSION →</b> has edited by BMJ editor</li> </ol>
G	Conclusions	<ol style="list-style-type: none"> <li>1. <b>Based on the author guidelines, please write the article in 12 pt TNR font and 1,5 spacing →</b> has edited by BMJ editor</li> <li>2. <b>Please write CONCLUSIONS →</b> has edited by BMJ editor</li> <li>3. <b>Please add suggestions to the conclusion →</b> has edited by BMJ editor</li> </ol>
H	Table, figure and Reference	<ol style="list-style-type: none"> <li>1. <b>Please put the superscript after the dot at the end of the sentence →</b> has edited by BMJ editor</li> <li>2. <b>Our journal adopts the “Vancouver Superscript” as the choice of citation format. Please format your inline citation and bibliographic as an example given below in: →</b> has edited by BMJ editor        --Inline citation—        Ponten et al., showed that fasciocutaneous flap could be utilized to cover lower leg soft tissue defects.<sup>1</sup> </li> </ol>



		<p>--Bibliographic--</p> <p>1. Pontén B. The fasciocutaneous flap: its use in soft tissue defects of the lower leg. Br J Plast Surg. 1981;34(2):215–20. Available from: <a href="http://www.ncbi.nlm.nih.gov/pubmed/7236984">http://www.ncbi.nlm.nih.gov/pubmed/7236984</a></p>
I	Others	<ol style="list-style-type: none"> <li>1. Please provide a statement regarding Author Contribution, Ethical Consideration, Funding, Conflict of Interest → has edited by BMJ editor</li> <li>2. At the top of the article, the type of article is added, namely the original article → has edited by BMJ editor</li> <li>3. Please write scientific names only in italics on the first and second word → has edited by BMJ editor</li> <li>4. Please revise some grammar mistakes → has edited by BMJ editor</li> <li>5. Checklist was attached below</li> </ol>

## **EXPLANATION FOR THE CRITICAL APPRAISAL TOOL FOR QUASI-EXPERIMENTAL STUDIES**

*How to cite: Tufanaru C, Munn Z, Aromataris E, Campbell J, Hopp L. Chapter 3: Systematic reviews of effectiveness. In: Aromataris E, Munn Z (Editors). JBI Manual for Evidence Synthesis. JBI, 2020. Available from <https://synthesismanual.jbi.global>*

### **Critical Appraisal Tool for Quasi-Experimental Studies (Experimental Studies without random allocation)**

Answers: Yes, No, Unclear or Not/Applicable

#### **1. Is it clear in the study what is the ‘cause’ and what is the ‘effect’ (i.e. there is no confusion about which variable comes first)? YES**

Ambiguity with regards to the temporal relationship of variables constitutes a threat to the internal validity of a study exploring causal relationships. The ‘cause’ (the independent variable, that is, the treatment or intervention of interest) should occur in time before the explored ‘effect’ (the dependent variable, which is the effect or outcome of interest). Check if it is clear which variable is manipulated as a potential cause.

Check if it is clear which variable is measured as the effect of the potential cause. Is it clear that the ‘cause’ was manipulated before the occurrence of the ‘effect’?

#### **2. Were the participants included in any comparisons similar? YES**

The differences between participants included in compared groups constitute a threat to the internal validity of a study exploring causal relationships. If there are differences between participants included in compared groups there is a risk of selection bias. If there are differences between participants included in the compared groups maybe the ‘effect’ cannot be attributed to the potential ‘cause’, as maybe it is plausible that the ‘effect’ may be explained by the differences between participants, that is, by selection bias. Check the characteristics reported for participants. Are the participants from the compared groups similar with regards to the characteristics that may explain the effect even in the absence of the ‘cause’, for example, age, severity of the disease, stage of the disease, co-existing conditions and so on? [NOTE: In one single group pre-test/post-test studies where the patients are the same (the same one group) in any pre- post comparisons, the answer to this question should be ‘yes.’]

#### **3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest? YES**

In order to attribute the ‘effect’ to the ‘cause’ (the exposure or intervention of interest), assuming that there is no selection bias, there should be no other difference between the groups in terms of treatments or care received, other than the manipulated ‘cause’ (the intervention of interest). If there are other exposures or treatments occurring in the same time with the ‘cause’, other than the intervention of interest, then potentially the ‘effect’

cannot be attributed to the intervention of interest, as it is plausible that the ‘effect’ may be explained by other exposures or treatments, other than the intervention of interest, occurring in the same time with the intervention of interest. Check the reported exposures or interventions received by the compared groups. Are there other exposures or treatments occurring in the same time with the intervention of interest? Is it plausible that the ‘effect’ may be explained by other exposures or treatments occurring in the same time with the intervention of interest?

#### **4. Was there a control group? YES**

Control groups offer the conditions to explore what would have happened with groups exposed to other different treatments, other than to the potential ‘cause’ (the intervention of interest). The comparison of the treated group (the group exposed to the examined ‘cause’, that is, the group receiving the intervention of interest) with such other groups strengthens the examination of the causal plausibility. The validity of causal inferences is strengthened in studies with at least one independent control group compared to studies without an independent control group. Check if there are independent, separate groups, used as control groups in the study. *[Note: The control group should be an independent, separate control group, not the pre-test group in a single group pre-test post-test design.]*

#### **5. Were there multiple measurements of the outcome both pre and post the intervention/exposure? YES**

In order to show that there is a change in the outcome (the ‘effect’) as a result of the intervention/treatment (the ‘cause’) it is necessary to compare the results of measurement before and after the intervention/treatment. If there is no measurement before the treatment and only measurement after the treatment is available it is not known if there is a change after the treatment compared to before the treatment. If multiple measurements are collected before the intervention/treatment is implemented then it is possible to explore the plausibility of alternative explanations other than the proposed ‘cause’ (the intervention of interest) for the observed ‘effect’, such as the naturally occurring changes in the absence of the ‘cause’, and changes of high (or low) scores towards less extreme values even in the absence of the ‘cause’ (sometimes called regression to the mean). If multiple measurements are collected after the intervention/treatment is implemented it is possible to explore the changes of the ‘effect’ in time in each group and to compare these changes across the groups. Check if measurements were collected before the intervention of interest was implemented. Were there multiple pre-test measurements? Check if measurements were collected after the intervention of interest was implemented. Were there multiple post-test measurements?

#### **6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed? YES**

If there are differences with regards to the loss to follow up between the compared groups these differences represent a threat to the internal validity of a study exploring causal effects as these differences may provide a plausible alternative explanation for the observed ‘effect’ even in the absence of the ‘cause’ (the treatment or exposure of interest). Check if there

were differences with regards to the loss to follow up between the compared groups. If follow up was incomplete (that is, there is incomplete information on all participants), examine the reported details about the strategies used in order to address incomplete follow up, such as descriptions of loss to follow up (absolute numbers; proportions; reasons for loss to follow up; patterns of loss to follow up) and impact analyses (the analyses of the impact of loss to follow up on results). Was there a description of the incomplete follow up (number of participants and the specific reasons for loss to follow up)? If there are differences between groups with regards to the loss to follow up, was there an analysis of patterns of loss to follow up? If there are differences between the groups with regards to the loss to follow up, was there an analysis of the impact of the loss to follow up on the results?

### **7. Were the outcomes of participants included in any comparisons measured in the same way? YES**

If the outcome (the ‘effect’) is not measured in the same way in the compared groups there is a threat to the internal validity of a study exploring a causal relationship as the differences in outcome measurements may be confused with an effect of the treatment or intervention of interest (the ‘cause’). Check if the outcomes were measured in the same way. Same instrument or scale used? Same measurement timing? Same measurement procedures and instructions?

### **8. Were outcomes measured in a reliable way? YES**

Unreliability of outcome measurements is one threat that weakens the validity of inferences about the statistical relationship between the ‘cause’ and the ‘effect’ estimated in a study exploring causal effects. Unreliability of outcome measurements is one of different plausible explanations for errors of statistical inference with regards to the existence and the magnitude of the effect determined by the treatment (‘cause’). Check the details about the reliability of measurement such as the number of raters, training of raters, the intra-rater reliability, and the inter-raters reliability within the study (not to external sources). This question is about the reliability of the measurement performed in the study, it is not about the validity of the measurement instruments/scales used in the study. *[Note: Two other important threats that weaken the validity of inferences about the statistical relationship between the ‘cause’ and the ‘effect’ are low statistical power and the violation of the assumptions of statistical tests. These other threats are not explored within Question 8, these are explored within Question 9.]*

### **9. Was appropriate statistical analysis used? YES**

Inappropriate statistical analysis may cause errors of statistical inference with regards to the existence and the magnitude of the effect determined by the treatment (‘cause’). Low statistical power and the violation of the assumptions of statistical tests are two important threats that weakens the validity of inferences about the statistical relationship between the ‘cause’ and the ‘effect’. Check the following aspects: if the assumptions of statistical tests were respected; if appropriate statistical power analysis was performed; if appropriate effect sizes were used; if appropriate statistical procedures or methods were used given the number and type of dependent and independent variables, the number of study groups, the nature of the relationship between the groups (independent or dependent groups), and the objectives of statistical analysis (association between variables; prediction; survival analysis etc.).





## ORIGINAL ARTICLE

### **Spiritual care on quality of life patients exposed to COVID-19 in the city area of Semarang**

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#### **ABSTRACT**

**Introduction:** Caring is a basic professional character that nurses must have in providing nursing care, including patients exposed to COVID-19, where nurses play an important position in maintaining their quality of life. This study aimed to find out the spiritual caring of nurses in this case is altruistic caring and humanistic caring on the quality of life of patients exposed to COVID-19 in the physical, psychological, social, and environmental dimensions.

**Methods:** This research was correlational using a cross-sectional approach to 118 respondents, namely patients exposed to COVID-19, both those being treated in isolation at the hospital, as well as independent isolation using the purposive sampling method. The instrument used in this study is the quality of life questionnaire which consists of 4 dimensions and a spiritual care questionnaire given by nurses.

**Results:** The research showed the characteristics of the sample were mostly women 83 (70.33%), the age of the respondents was at least 23 years and a maximum of 65 years, the most with undergraduate education as many as 53.38%; employment status 80.51% private employees, marital status 83.89% married; treatment status 82.20% hospitalized; length of hospitalization between 2 to 40 days with an average of 12.26 days; Most of the respondents are Muslim 95.76%. The value of altruistic caring is good (63.56%), humanistic caring is good (68.64%). The quality of life of respondents who were exposed to COVID-19 was mostly good, 66.94%.

**Conclusion:** There was a relationship between spiritual caring, both altruistic caring and humanistic caring, on the quality of life of patient respondents exposed to COVID-19, where the better the perception of spiritual caring the better the quality of life. This research can be used as evaluation material for nursing care providers to cultivate caring character to improve the quality of life of patients.

**Keywords:** spiritual caring, quality of life, patient exposed, COVID-19

#### **INTRODUCTION**

COVID-19 is a contagious infection by the SARS-Cov-2 virus, attacks the respiratory system through droplet infection by direct contact with patients and can cause death, only

patients who are calm, do not panic, are not afraid and are not stressed, have a better quality of life, so patients really need support by nurse (caring).<sup>1,2</sup>

Caring is a basic professional character that nurses must have in providing nursing care, including patients exposed to COVID-19, where nurses play an important position in maintaining their quality of life.<sup>3,4</sup> Patients exposed to COVID-19 have high hopes of being able to recover from their condition. This hope can appear as a hope for God, because God is the source of the highest substance/strength.<sup>5-7</sup> Spiritual caring is the development of Caring theory with the addition of spiritual characters according to the needs of Covid 19 patients, this is because caring supplies alone are not enough. Spiritual and religious dimensions are the most chosen and felt aspects and the most needed by patients.<sup>8-10</sup>

The number of people exposed to COVID-19 in Indonesia is updated on June 8, (covid 19 task force, 2020) as follows; person under monitoring 38,791, patient under monitoring 14,010, positive 32,003, recovered 10,904, died 1,883. data from 34 provinces, and 422 regencies/cities. Nurses are required to be able to provide holistic and comprehensive services, one of which includes the patient's spiritual-religious needs. Nursing pioneer Florence Nightingale recognized the spiritual dimension of nursing care. According to him, the spiritual dimension is the deepest and most essential source of healing to overcome patient problems.<sup>11</sup>

Spiritual caring is one of the professional characteristics of nurses in the process patient management. Patients exposed to COVID-19 will have a better quality of life if have calm, resignation, sincerity, and low stress levels. Spiritual care is very necessary for patients exposed to COVID-19 to maintain a physical, psychological, social balance and spirituality.<sup>10</sup> Growing spiritual caring is not easy, it requires motivation and leadership support. In order for nurses to have this spiritual caring character, a pattern is needed leadership that leads to a spiritual pattern, therefore nursing leaders must can initiate spiritual leadership within himself, due to the application of spiritual leadership will cause a high sense of appreciation for others, improve the quality of good relationships, thereby fostering feelings of purpose and meaning.<sup>12</sup> Leadership is able to increase the personal personality of the individuals they lead to feel peace, pleasure, serenity and satisfaction so that it can be transmitted to others who around him, especially the nurses. Caring for patients exposed to COVID-19 requires attention greater size, so that the achievement of spiritual caring is expected to be formed in nurses managed by using spiritual leadership.<sup>13</sup> The specifications of this research are the generation of a model of achieving spiritual caring.

The importance of the spiritual aspect for patients exposed to Covid 19 is one way to increase the meaning and life expectancy, improve the quality of life, and increase self-confidence and can reduce patient anxiety.<sup>13,14</sup> therefore it is necessary to develop the spiritual caring character and spiritual leadership of nurses in improving the quality the lives of patients exposed to COVID-19 in maintaining their lives. The purpose of this study was to find out the spiritual caring of nurses in this case is altruistic caring and humanistic caring on the quality of life of patients exposed to COVID-19 in the physical, psychological, social, and environmental dimensions.

## **METHODS**

### **Study Design**

This research method used a correlational method with a cross-sectional approach, by measuring the spiritual caring of nurses and the quality of life of patients exposed to COVID-19. Spiritual caring was measured by using a questionnaire to determine the altruistic caring and humanistic caring of nurses. The quality of life of patients exposed to COVID-19 was measured using the WHO QOL questionnaire and what was measured were the physical dimensions, spiritual dimensions, social dimensions and environmental dimensions.

### **Population of the Study and Data Collecting**

The population in this study were patients who had been exposed to COVID-19 and were hospitalized or who were undergoing self-isolation, while the sampling technique was carried out purposively with inclusion criteria 1. Patients who tested positive for rapid antigen, 2. Patients who were hospitalized or who in independent isolation, 3 Willing to be a respondent, 4. Can communicate well, 5. Not in a severe condition. The number of samples obtained as many as 118 respondents. The research ethics used are informed consent, anonymity and confidentiality, human of dignity, and ethical clearance.

### **Data Analysis**

Data were entered and stored in Microsoft Excel 2016. Frequency, rates, and percentages were used to summarize categorical variables, the proportions of which were compared using Pearson's correlation. Statistical analysis was carried out using the SPSS statistical program version 22.

## **RESULTS**

The results of the study can be presented with tables and descriptive descriptions of the characteristics of respondents, spiritual caring, namely altruistic and humanistic caring and quality of life as follows:

**Table.1** Characteristics of Respondents exposed to Covid 19 by Age (n=118)

<b>Variabel</b>	<b>N</b>	<b>Min</b>	<b>Maks</b>	<b>Mean</b>	<b>Sd</b>
<b>Age</b>	118	23	65	33.68	8,78

The age of the respondents had a mean of 33.68 ( $\pm$  8.78) years, with the youngest age being 23 years old and the oldest being 65 years old. Based on the 95% Confidence Interval value, it can be predicted that the value of the Age variable in the sample is in the range of 32.08 - 35.28 years.

**Table.2** Characteristics of Respondents exposed to covid 19 by gender (n=118)

<b>No</b>	<b>Gender</b>	<b>Amount (f)</b>	<b>Percent (%)</b>
1	Male	35	29.67
2	Female	83	70,33
<b>Total</b>		118	100

Gender of respondents 35 (29.67%) are male and 83 (70.33%) are female.

**Table.3** Characteristics of Respondents exposed to covid 19 based on level Education (n=118)

<b>No</b>	<b>Level Education</b>	<b>Amount (f)</b>	<b>Percent (%)</b>
1	D3	15	12.71
2	Bachelor	63	53,38
3	Master	32	27,11
4	Doctoral	8	6,80
<b>Total</b>		118	100

The education level of 118 respondents (100%) has a higher education background, with a description of D3: 15 (12.71%) respondents, Bachelors: 63 (53.38%) respondents, Masters: 32 (27.11%) respondents, and doctoral 8 (6.80%) respondents

**Table.4** Characteristic of respondents exposed to covid 19 based on Employment Status (n=118)

No	Employment status	Amount (f)	Percent (%)
1	civil servant	23	19.49
2	Private employees	95	80,51
<b>Total</b>		118	100

The results showed that 23 (19.49%), worked as civil servants, and 95 (80.51%) as private employees.

**Table.5** Characteristics of respondents exposed to covid 19 based on marital status (n=118)

No	Marital status	Amount (f)	Percent (%)
1	Married	99	83.89
2	Not Merried	19	16,11
<b>Total</b>		118	100

The results showed that 99 (83,89%) married status, and 19 (16,11%) not married.

**Table.6** Characteristics of respondents exposed to covid 19 based on treatment status (n=118)

No	Treatment status	Amount (f)	Percent (%)
1	Self Isolation	21	17.80
2	hospitalized	97	82,20
<b>Total</b>		118	100

The results showed that 21 (17,80%), get self isolation treatment and 97 (82,20%) hospitalized

**Table.7** Characteristics of respondents exposed to covid 19 based on length of hospitalization (n=118)

Variabel	n	Min	Maks	Mean	sd
length of hospitalization	118	2	40	12.26	7,15

The results showed that the length of illness (days) had an average of 12.26 ( $\pm 7.15$ ) days of illness being 2 days and the highest length of illness being

**Table.8** Characteristics of respondents exposed to covid 19 based on religion/ belief (n=118)

No	Religion /belief	Amount (f)	Percent (%)
1	Muslim	113	95,76
2	Christian	4	3,39
3	Chatolic	1	0,85
<b>Total</b>		118	100

The results showed that 113 (95,76%) respondent are Muslim, 4 (3,39%) respondent are christian, and 1 (0,85%) respondent are chatolic

**Table.9** Nurses' spiritual caring perceived by respondents exposed to covid 19 (n=118)

Variabel	n	Min	Maks	Mean	sd
<i>Caring altruistik</i>	118	10	50	39.75	10,79
<i>Caring humanistik</i>	118	10	50	40,35	10,29

The results showed that altruistic caring had an average of 39.75 ( $\pm 10.79$ ) with the lowest altruistic caring being 10 and the highest altruistic caring being 50. Based on the 95% Confidence Interval value, it can be predicted that the value of the altruistic Caring variable in the population is in the range of 37.79 - 41.72. The category of Altruistic Caring that was received Good by the respondents based on their perception was 75 (63.56%) respondents, and 43 (36.44%) perceived the altruistic caring they received was not good.

The results showed that humanistic caring had an average of 40.35 ( $\pm 10.29$ ) with the lowest humanistic caring being 10 and the highest humanistic caring being 50. Based on the 95% Confidence Interval value, it can be predicted that the value of the Humanistic Caring variable in the population is in the range of 38.47 - 42.22. The category of Humanistic Caring received by respondents was good based on their

perceptions as many as 81 (68.64%) respondents, and 37 (31.36%) perceived the humanistic caring they received was not good.

**Table.10** Quality of life respondents exposed covid 19 (n=118)

Variabel	n	Min	Maks	Mean	sd
Physical Dimention	118	19	35	27.58	(±3,33)
Psychological Dimention	118	19	30	26,23	(±2,55)
Social Dimention	118	9	15	12,38	(±1,54)
Environtmental Dimentio	118	24	40	32,91	(±3,78)
Over all quality of life	118	78	129	107,38	(± 10,41)

The results showed that the average physical dimension was 27.58 ( $\pm 3.33$ ) with the lowest physical dimension being 19 and the highest physical dimension being 35. Based on the 95% Confidence Interval value, it can be predicted that the value of the physical dimension variable in the population is in the range of 26.98 - 28.19. Categorical analysis of respondents with good quality of life in physical dimensions as many as 61 (51.69%) respondents, and poor physical dimensions as many as 57 (48.31%) respondents.

The results showed that the psychological dimension had an average of 26.23 ( $\pm 2.55$ ) with the lowest psychological dimension being 19 and the highest psychological dimension being 30. Based on the 95% Confidence Interval value, it can be predicted that the value of the psychological dimension variable in the population is in the range of 25.76 - 26.69. The categorical analysis of respondents with good quality of life on the psychological dimension was 45 (38.13%) respondents, and the psychological dimension was not good as many as 73 (61.87%) respondents.

The results showed that the social dimension had an average of 12.38 ( $\pm 1.54$ ) with the lowest social dimension being 9 and the highest social dimension being 15. Based on the 95% Confidence Interval value, it can be predicted that the value of the social dimension variable in the population is in the range of 12.1 - 12.66. The categorical analysis of respondents with quality of life on the social dimension is good as many as 43 (36.45%) respondents, and the social dimension is not good as many as 75 (63.55%) respondents.

The results showed that the environmental dimension had a mean of 32.91 ( $\pm 3.78$ ) with the lowest environmental dimension being 24 and the highest environmental dimension being 40. Based on the 95% Confidence Interval value, it can be predicted that the value of the environmental dimension variable in the population is in the range of 32.22 - 33.6. The

categorical analysis of respondents with good quality of life on environmental dimensions was 54 (45.76%) respondents, and 64 (54.24%) respondents in poor environmental dimensions.

The results showed that the patient's quality of life had an average of 107.38 ( $\pm$  10.41) with the lowest patient's quality of life being 78 and the highest patient's quality of life being 129. Based on the 95% Confidence Interval value, it can be predicted that the value of the patient's quality of life variable in the population is in the range of 105.48 - 109.28.

The categorical analysis of respondents with good quality of life was 79 (66.94%) respondents, and 39 (33.06%) respondents had poor quality of life.

### **Relationship between Caring Nurses and Respondents' Quality of Life**

The results of the correlation test are known that there is a significant relationship between the altruistic caring variable and the quality of life of COVID-19 patients ( $p = 0.0001$ ,  $P < 0.05$ ), and the value of  $r = 0.413$ . Based on the value of the correlation coefficient between the two variables, it can be seen the strength the relationship between the two variables is in the moderate category, with a unidirectional relationship, it can be concluded that the better the altruistic caring given by the nurse to the respondent, the better the quality of life when exposed to COVID-19.

The results of the correlation test showed that there was a significant relationship between the humanistic caring variable and the quality of life of COVID-19 patients ( $p = 0.0001$ ,  $P < 0.05$ ), and the value of  $r = 0.429$ . Based on the value of the correlation coefficient between the two variables, it can be seen that the strength of the relationship between the two variables is in the medium category, with a unidirectional relationship, it can be concluded that the better humanistic caring, the better the quality of life of patients exposed to COVID-19

## **DISCUSSION**

Quality of life is a person's perception as an individual related to their position in life seen from the context of the culture and value system in which they live and its relationship to goals, expectations, standards, and other things that concern the individual. Quality of life is directly affected by positive parenting experiences, negative parenting experiences, and chronic stress. Economic resources and social resources have a direct impact on the quality of life. The results of the analysis in this study showed that spiritual caring affects the quality of life of patients exposed to COVID-19. value of  $r = 0.429$ . Based on the value of the



correlation coefficient between the two variables, it can be seen that the strength of the relationship between the two variables is in the medium category, with a unidirectional relationship, it can be concluded that the better humanistic caring, the better the quality of life of patients exposed to COVID-19.

This is supported by Ghozally that the factors that affect the quality of life include self-recognition, adaptation, feeling the suffering of others, feelings of love and affection, being optimistic, developing an attitude of empathy. as a recipient of nursing services. Quality of life of patients exposed to COVID-19, whether self-isolated or treated in an inpatient room (covid isolation) for physical dimensions. Respondents admitted to experiencing physical discomfort due to infection with the SARS-CoV-2 virus, which causes fever, runny nose, chills, anosmia, to shortness of breath so that there is a decrease in activity, physical condition and weakness, limited muscle strength so easily tired.<sup>15</sup> The psychological dimension is due to high anxiety as a result of exposure to viral infections and the prognosis of diseases that increase anxiety, the social dimension is due to having to be separated from family and social conditions, because as social beings, respondents as patients exposed to this virus experience social problems, even loneliness and isolation due to isolation. independence and isolation treatment, environmental dimensions that must be out of the environment that has been in the comfort zone in their environment.<sup>16</sup>

Several factors can affect a patient's quality of life such as age, gender, level of education, occupation, marital status, finances and reference standards, but in this study all these factors did not directly correlate with the quality of life of patients exposed to COVID-19. Quality of life consists of physical, psychosocial, social and environmental dimensions.<sup>17</sup>

Factors that influence the quality of life in this study are altruistic caring and humanistic caring, indicated by statistical analysis with p value 0.05 and have a relationship pattern that is directly proportional to the closeness of the relationship, which means the better the altruistic caring of the nurse, the better. the quality of life of respondents exposed to COVID-19, and the better the nurse's humanistic caring, the better the quality of life of the respondent exposed to COVID-19.<sup>18</sup> This is because humanistic caring as a reflection of attention, feelings of empathy and compassion for others, and is carried out by providing concrete actions caring with the aim of improving the quality and living conditions of respondents exposed to COVID-19. altruistic caring is the provision of help by nurses to respondents exposed to COVID-19 which is given purely, sincerely, without expecting any return (benefit) for him, with the main goal solely eyes to improve the welfare of others

(respondents who are helped), and altruistic behavior is a voluntary action by nurses and helping others selflessly, because they only want to do good deeds.<sup>19</sup>

## **Conclusion**

Nurse altruistic caring was perceived as good as much as 63.56%, while humanistic caring was perceived as good as much as 68.64%. There was a relationship between altruistic caring and the quality of life of patient respondents exposed to covid 19, where the better the perception of altruistic caring, the better the quality of life. There was a relationship between humanistic caring and the quality of life of patient respondents exposed to COVID-19, where the better the perception of humanistic caring, the better the quality of life. Further study with larger sample size and more comprehensive design are needed to support these findings.

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## **Conflict of interest**

No potential conflict of interest relevant to this article was reported.

## **Author Contribution**

All authors were responsible for data gathering, supervision, and writing the original draft. All authors had reviewed the final version of the manuscript.

## **Ethical Consideration**

The investigators agreed to conduct this study in full agreement with the principles of the Declaration of Helsinki' and its subsequent related amendments. This study was approved by the Ethics Committee of the Faculty of Nursing and Health Sciences, Universitas Muhammadiyah Semarang, Semarang, Indonesia. Letter of exemption Ref. No. 1288/EC.KEPK/UMS/2020.

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