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Nursing professionals' education on the spiritual dimension of critical patients

A formação de profissionais de enfermagem frente à dimensão espiritual do paciente crítico

Formación de profesionales de enfermería sobre la dimensión espiritual del paciente crítico

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ABSTRACT

Objective: To describe and analyze the nursing professionals' education on the spiritual dimension of critically ill patients.

Methodology: A qualitative, descriptive, exploratory study, using the Thematic Oral History as a framework. Fourteen nursing professionals from a teachinghospital in the city of São Paulo participated in the study from March to April 2021. The professionals were interviewed by following a script of questions and their speeches were transcribed, transcreated and submitted to Bardin's content analysis, in the thematic modality.

Results: Three categories emerged from the analysis of the narratives: Concept of spirituality; Spirituality in Nursing education and Spirituality in the intensive care unit.

Conclusion: Nursing practice in assisting critical patients' spiritual dimension is based on their religious practices and professional experiences, because the theme is not part of the basic curriculum in nursing education, whether at a technical or at an academic level.

Keywords: Spirituality. Education, nursing. Critical care nursing.

RESUMO

Objetivo: Descrever e analisar a formação dos profissionais de enfermagem para a atenção à dimensão espiritual do paciente crítico.

Metodologia: Pesquisa descritivo exploratória, de natureza qualitativa, utilizando a História Oral Temática como referencial. Catorze profissionais de enfermagem de um hospital universitário da cidade de São Paulo participaram do estudo no período de março a abril de 2021. Os profissionais foram entrevistados seguindo-se um roteiro de perguntas e seus discursos foram transcritos, transcriados e submetidos à análise de conteúdo proposta por Bardin, na modalidade temática.

Resultados: Três categorias emergiram das análises das narrativas: Conceito de espiritualidade; Espiritualidade na formação de Enfermagem e Espiritualidade na Unidade de Terapia Intensiva.

Conclusão: A assistência de enfermagem à dimensão espiritual do paciente crítico é baseada em suas práticas religiosas e vivências profissionais, pois a temática não faz parte do currículo básico de conhecimentos na formação, tanto no nível técnico quanto no superior.

Palavras-chave: Espiritualidade. Educação em enfermagem. Enfermagem de cuidados críticos.

RESUMEN

Objetivo: Describir y analizar la formación de profesionales de enfermería para el cuidado de la dimensión espiritual del paciente crítico.

Metodología: Investigación exploratoria descriptiva, de carácter cualitativo, teniendo como referencia la Historia Oral Temática. Participaron de la investigación 14profesionales de enfermería de un hospital universitario de la ciudad de São Paulo, de marzo a abril de 2021. Se entrevistaron los profesionales siguiendo un guion de preguntas y sus discursos fueron transcriptos, transcreadosy sometidos al análisis de contenido propuesto por Bardin, en la modalidad temática.

Resultados: Tres categorías surgieron del análisis de las narrativas: Concepto de espiritualidad; Espiritualidad en la formación de Enfermería y Espiritualidad en la Unidad de terapia intensiva.

Conclusión: La práctica de enfermería en la asistencia a la dimensión espiritual del paciente crítico se basa en sus prácticas religiosas y experiencias profesionales, ya que el tema no forma parte del currículo básico de conocimientos en la formación de enfermería.

Palabras clave: Espiritualidad. Educación en enfermería. Enfermería de cuidados críticos.

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INTRODUCTION

Nursing professionals exercise the science and art of caring for human beings in all dimensions and stages of the life cycle. They are among the few professions that participates in people's lives from the moment they are born, in scenarios of joy or sadness, pleasure or suffering. These professionals need consistent training in Behavioral, Social, Life and Nursing Sciences, for the adequate performance of their activities of health promotion, disease prevention and delivery of care to sick people[1], as well as scientific support in their practices and resources to be able to provide compassionate, ethical, safe, scientific and technical care[2].

Nursing care informed by good practices is based on the professional design established by the precursor of modern Nursing, Florence Nightingale. Nightingale described her theory according to the scientific precision of her time, without making human needs invisible, considering the restoration of health as the result of effective care for the physical, mental and emotional/spiritual dimensions of an individual[3].

Spirituality is inseparable from the human condition and plays an important role in the process of healing and coping with diseases, giving meaning to people's lives (patients and family members) in situations of adversity and suffering[4–7]. According to the literature, the attributes of spirituality include, but are not limited to, connection with oneself, with others, with God, with nature; to the essence of the human being; to an existential experience; happiness, harmony, hope, individual and universal transcendence; inner strength, meaning, purpose; renouncing living an empty and superficial life, and to self-fulfillment[8,9].

When people's spiritual dimension is assisted, there are several positive effects on the physical-mental and spiritual dimensions of patients and their families, according to studies[4,8,9]. Care to the spiritual dimension is considered an integral part of nursing care by several world nursing organizations, such as the American Association of Critical Care Nurses (AACN)[2], the International Council of Nurses, the Joint Commission, the American Association of Nursing Universities and, more recently, the Nursery Midwifery Council[7].

Thus, it is imperative that healthcare providers are prepared to deal with the spiritual needs of patients and their families[4]. Because the nursing team spends 24 hours uninterruptedly at the bedside of patients, they will often be the professionals responsible for identifying and meeting those needs[8]. For this purpose, nurses and nursing technicians (NTs) use their professional skills, offering active, compassionate and sensitive listening, and provide people with the conditions to rediscover their meanings and purposes in life, to find support and strategies for coping with stressful situations[7–9].

This tipe of care has been widely debated in the last two decades and, despite the efforts of researchers and nursing organizations, this practice is not very noticeable. Studies have shown that the understanding of spirituality and spiritual care, as well as the dissociation between spiritual care and nursing care, are closely related to the limited training of these professionals with regard to the conceptual understanding of the phenomenon. Many health care providers do not provide this care, as they correlate the theme with religion and, therefore, fear imposing their beliefs on patients or fear facing their own spiritual vulnerability[8,10].

In Brazil, the professional skills required for the ideal training of nurses are dictated by the National Curricular Guidelines (NCG) for Nursing[1]. The other nursing professionals (NTs and nursing assistants) are not subject to a national curriculum guideline. Their training is provided by technical schools and health services, and their framework is defined by the needs of the labor market[12].

As in any regulation of a healthcare profession, it is recommended the training of a generalist, critical, reflective and ethical professional, endowed with vast technical-scientific knowledge[1]. However, contrary to holistic critical thinking in Nursing, the NCG do not mention the spiritual dimension in their description of comprehensive care for human beings[3,11].

As for nursing training in the field of intensive care, there are few publications on spiritual care for critically-ill patients[4]. This is remarkable, since people who are admitted to this unit experience spiritual distress[9]. In healthcare services, lack of concern with spirituality of critical individuals is frequent, either due to organizational constraints, unpreparedness or omission of health care providers and, particularly, nursing professionals, who more often share the distress of patients and families[4–9].

To understand this phenomenon and seek alternatives to change this reality, it is necessary to investigate the training process of these professionals. In the era of discussions about human pluralities and people-centered care, this paper intends to highlight the spiritual dimension as a powerful body integrated into human nature and, therefore, a body that must also be incorporated into the range of knowledge, attitudes, and skills that new nursing professionals must have and be able to offer their patients. Thus, the present study aims to describe and analyze the training of nursing professionals for the care to the spiritual dimension of critically ill patients.

METHOD

A qualitative, descriptive-exploratory study that used Oral History as a methodological framework[13,14]. The project was approved by the Ethics and Research Committee at *Universidade Federal de São Paulo* (UNIFESP), Protocol no 4.526.466 and CAAE no. 38351520.70000.5505. The study was conducted in accordance with all the recommendations of Resolution no. 466/12, of the National Health Council[15] and reported according to COREQ guidelines[16]. All participants signed a consent form.

Thematic Oral History (TOH) was adopted because it enables the elaboration of a project that systematically allows access to a more subjective field of the participants' experiences, a fact that coincides with the subjectivity of the central theme of the study, the spiritual dimension. This methodological framework allows the researcher to elucidate a phenomenon that is poorly understood or controversial through oral expression memories, generating new knowledge[13,14].

The study was conducted in a tertiary, large, high-complexity teaching hospital, located in the southern area of the city of São Paulo. The hospital is a reference in the coverage of a region with more than five million inhabitants (Greater São Paulo), in addition to assisting patients from all over the country[17]. Most users of the service are from the Unified Health System. The service provides care in all medical specialties, including highly complex procedures.

The institution had 10 Intensive Care Units (ICU) at the time the study was carried out[17]. The Anesthesiology Center of Critical Care was selected as the study setting due to its heterogeneous profile, assisting highly complex surgical and clinical patients, i.e., individuals who experience moments of physical, mental and possibly spiritual vulnerability. This Center of Critical Care was composed of four ICUs, two of which were intended exclusively for patients with COVID-19 and the other two for the care of other clinical and/or surgical cases. The general staff of the Anesthesiology Center of Critical Care had 200 nursing professionals delivering direct patient care during the data collection period (March and April 2021); Professionals absent from work were not included in this amount. As this is a study of qualitative reflections, participants' selection was based on their diverse experiences with the theme, since critical patients required full-time nursing care.

To cover and reach a sufficient degree of qualitative evidence, sample diversification and saturation criteria were followed[18]. Diversification expands the analysis of the theme through the perspective of different subjects, from the same target social group. In turn, saturation indicates that interviews should be interrupted to avoid data with little relevance. To ensure the diversification of the sample, the inclusion criteria of the study were nursing professionals delivering direct patient care, with at least two years of experience working in ICU and available to participate in interviews during the data collection period.

A two-year period of experience was established because it is the minimum time for nurses to reach a "competent" level of clinical expertise, according to Benner's theory of levels[19]. A "competent" nurse is one who has been working in the field for more than two years, with clear technical procedural skills and making few mistakes during delivery of nursing care. At this level, nurses are able to independently deliver care regardless of the clinical event during their professional practice[19]. Nurses and NTs were interviewed, as the knowledge acquired in their life and work experiences provides a greater understanding of the investigated phenomenon. Nursing professionals absent from the unit during data collection (on vacation and medical leaves or other types of leave) were excluded from the study.

In the hospital where the study was developed, the work schedule is divided into teams on duty in the morning, afternoon and night shifts I and II (12h x 36h). To better describe the training of nursing professionals in caring for the spiritual dimension of critically ill patients, one nurse and one NT from each shift were chosen (totaling eight professionals interviewed at the first moment). Stratified random sampling was used in the selection of the participants. The total population of nursing professionals per shift was entered into an online draw platform. For each shift, two draws were held (one for nurses and another for NTs). This procedure was repeated for the four shifts. After each draw, the inclusion criteria were applied (more than two years of experience and not on a leave) and finally the participant was contacted.

After application of the inclusion criteria, the participant drawn from each professional occupation (nurse or NT) was contacted by the main researcher, through a text message, in which general concepts of the study were presented and consent to participate was requested. If the answer was positive, the consent form and additional information about the study were sent to the participant by email. The interview was also scheduled. Of the 16 potential participants, two NT withdrew from participating in the research, and were not replaced by two other professionals in their professional occupation, due to data saturation and diversification of the sample (eight nurses and six NTs) at the time of withdrawal. All participants returned the consent forms with a digital signature on the day of the interview.

The interviews were carried out by telephone, and lasted about 10 to 20 minutes, depending on the date and time agreed according to the availability of the participants. The possibility of interviews being carried out via video calls was disregarded, as the absence of videos would not have an impact on the understanding of the phenomenon.

The interviews were carried out according to a script with10 open-ended flexible questions, providing a free space for the expression of memory and dialogic exercise, as recommended by TOH[13,14]. The same procedure was used in all interviews: first, apresentation of the study, explaining its intentions, justifications, objectives and procedures of the TOH methodology[14], followed by confirmation of consent to record the conversation. The first part of the dialogue involved collecting sociodemographic data from respondents. Then, questions were asked about the understanding of the phenomenon and the teaching of the phenomenon during their professional education. All interviews were conducted in a room with a single window and door. Both the door and the window remained closed during the conversation and were used only by the interviewer.

The dialogues were recorded with the use of a free sound recording application via cell phone and all participants were identified with the letter "I" for Interviewee, followed by a numerical sequence corresponding to the order in which the interviews were carried out (I1, I2, …, I14), to ensure anonymity. In each interview, the particularities of the interviewed individual were considered, ensuring comfort, freedom of expression and narrative conditions to guarantee their performance[14]. Audio files and interview records followed the recommendations of Resolution no. 466/12, of the National Health Council[15] and the General Data Protection Law[20].

To transform the oral code into a written code, the scientific method of TOH[13,14] was followed, according to the following steps: transcription, textualization, choice of vital tone and transcreation. After the recording, the first phase was carried out, consisting of literal transcription of the interviews, including colloquialisms, sounds and noises. In the subsequent step, the transcripts were textualized. It was aprocess that required readings and re-readings by the researchers. In this TOH phase, the interviews are textualized to make the narrative more understandable for the reader, and it is also in this phase that the "vital tone" of the interview is found. The textualizations were read and reread in search of guiding axes for coding and categorization of information, according to the purpose of the study. Data saturation was reached after the 14th interview and sample diversification was ensured through the participation of nurses and NTs from all work shifts, covering the 24 hours of experiences with critically ill patients Then, transcreation of the narratives was carried out, which consists of adapting them to the written language, without losing the essence of the content of the statements. Prior to content analysis, all transcreated narratives were screened by two reviewers, thus reducing the impact of transcreative freedom[13,14].

All testimonies were submitted to thematic content analysis proposed by Bardin[21], which comprises three basic stages of analysis: pre-analysis (selection of the material), analytical description (thorough investigation of the material, using hypotheses and theoretical references) and inference (the material is treated through coding, classification and interpretation).

RESULTS

The study included 10 female and four male professionals (n=14), aged 28-57 years, as follows: eight nurses and six nursing technicians. The length of professional experience of nurses ranged from six to 27 years and they had been working in intensive care for four to 21 years. As for NTs, the length of time working in the profession ranged from 12 to 34 years, and they had been working in intensive care for five to 24 years. Most respondents worked during the day (n=8). All nurses interviewed had expertise in critical areas.

Most professionals adhered to Christian religions, with four Catholics, four Evangelicals and two Kardecist-Spiritists. As for the others, two called themselves spiritualists (believers in spirituality free of religious dogmas) and two agnostics.

The professionals' narratives culminated in the creation of three categories: concept of spirituality, spirituality in nursing education and spirituality in the ICU. Content analysis generated 68 recording units (RUs), which were grouped into 16 codes, 14 subcategories and three categories, as shown in Chart 1.

The assumptions identified in **Concept of spirituality** showed that professionals had extensive knowledge about this complex concept, understanding that this human dimension provides vital energy, support and strength to face the daily routine.

The participants understand that the spiritual dimension is free from the doctrinal precepts of religious practice and divine belief and that interaction with their spiritual dimension provides human beings not only with an understanding of the particularities of each one's life, but also of their interaction with the environment and with the other, giving purpose and meaning to life. However, despite the understanding of the universality and singularity of the

concept of spirituality on the individuals, conceptual convergences between the terms Spirituality and Religion still provoke a conceptual conflict in healthcare professionals. There is often an understanding that a professional's religion structures their ability to care for the spiritual dimension of the patient:

> *It's what connects you with something bigger, nourishes you, and makes you stronger, more peaceful and confident in the future.* (I10)
>
> *It's about connecting your thoughts with something bigger and realizing that there are things beyond your body, forces that work to make things happen, regardless of whether you believe in God or not, regardless of religion.* (I02)
>
> *I like to think that the concept of spirituality is something very particular. There are people who believe in God, others in different deities, and there are also those who believe in the higher power of nature.* (I05)
>
> *I don't feel able to intervene with religions different from mine, even if we have the search for the divine as something in common.* (I01)
>
> *I realize that, in addition to the fact that this care depends on the patient's will, it also depends on the professional's religiosity.* (I07)

With regard to **Spirituality in nursing education**, awareness of the importance of the spiritual dimension in the lives of nursing professionals was identified as the main factor that supports the provision of spiritual care. From a technical point of view, professionals reported the absence of this content in their education. Their professional conduct is based on ethical precepts:

> *Sometimes in my life I disconnected from my spirituality and felt a great void. It was then that I realized this is something very important to me.* (I10)
>
> *No professor has ever explained that it is part of the nursing process to know the patient's culture and religion, because then the nurse can help the patient to strengthen his meaning of life during the illness process. I only learned about it during my professional experience.* (I03)
>
> *I really think that I have to rely on my religious background to develop my work as a nurse in the field of spirituality* (I02)
>
> *Religion and spirituality are subjects that should be taught in the Nursing school... However, throughout my training as a technician and nurse, I've never had contact with these topics.* (I04)
>
> *In college...] I learned that we should be ethical and respect all religions without distinction. (I09)*

Code	Subcategory	Category
C1	Meaning of life	Concept of spirituality
C2, C3 and C12	Connection with oneself, with others and God	
C4	Connection with the transcendent	
C5	Vital energy	
C11	Support and peace of mind	
C9	Conceptual conflict between spirituality and religion	
C10	Connection with nature	
C14	Individual and subjective characteristic	
C16	Principle of respect for the person or autonomy	Spirituality in Nursing education
C15	Spiritual carelearned through religion	
C8	Fragmented professional practice as a reflection of fragmented teaching	
C7	Focus on biomedical care in ICU	Spirituality in the Intensive Care Unit
C6	Mechanical and biological nursing care	
C13	Organizational culture as an obstacle	

Chart 1 – Codes and grouping of subcategories for the elaboration of the study categories. São Paulo, São Paulo, Brazil, 2021
Source: Research data, 2021

The narratives that culminated in the category **Spirituality in the Intensive Care Unit** showed that the characteristics of an ICU, such as highly dependent patients and technological density, are in conflict with nursing care to abstract human dimensions. Due to the challenging goal of maintaining a life impacted by a serious illness, technological resources, alarms and high work demand are part of the routine of professionals working in this sector:

> *The dynamics of intensive care is still very biological, very technical, and we have our duties and tasks as nurses in charge of patients. Sometimes, when we have to deal with a spiritual demand from the patient, we try not to get involved. (I01)*
>
> *Due to the work dynamics of the sector, regarding noise and other aspects, it is very difficult for us to focus on the spirituality of patients [...] Due to lack of knowledge, health professionals do not understand the importance of the spiritual connection of patients and their families, and so they interrupt a prayer to perform an elective procedure, for example. (I10)*
>
> *This topic should be widely discussed in the ICU, as this sector is very technical and technological, and we often provide mechanized care, forgetting that it is not just a patient connected to devices. (I06)*

Several factors influence the provision of spiritual care by the nursing team. Elements arising from the health professionals' human experience, their understanding of interrelated concepts and, mainly, the lack of proper education, directly impact the provision of holistic care. In an ICU, these factors are even more pronounced due to the sector's massive biological and technical focus.

DISCUSSION

The fact that most study participants were women corroborates the Research Profile of Nursing in Brazil[22], conducted by FIOCRUZ/COFEN, which demonstrates that it is an eminently female profession (85.1%). According to the last census of São Paulo, the participants of the present study reflect the spiritual and religious profile of the population, in which 80% declared themselves as Christian adherents[23].

All professionals interviewed mentioned key elements that are universal to the concept of spirituality, in its most diverse meanings and cultures[4–7], and also stated that this dimension is important in their lives. Even those who declared themselves agnostics affirmed the importance of this dimension in their lives. These two characteristics (understanding of the concept of spirituality and spiritual awareness) are basic assumptions that nursing professionals must have during their training process[5–9]. However, scholars on the subject have pointed out, especially in the last decade, that both the theme of spirituality and spiritual care are neglected by the various nursing training centers around the world[7,8,24].

Noting the absence of a standard in the curricular matrix regarding the education of nurses in spiritual care, specialists on the subject in Europe carried out the first movement towards the construction of a common curricular guideline in this area. This project brought together three groups from the most diverse cultural settings on the European continent (21 countries), composed of the main theorists on spiritual care in Nursing. According to several studies, one of the main difficulties for establishing a standard in spiritual care is the cultural influence of its concept. Therefore, this consensus aimed to facilitate the adequacy of nursing curricula in Europe, so that consistent education based on spiritual competences builds a nursing practice that transcends the limits of local culture[7,24]. Through this guideline, the main knowledge, skills and attitudes expected in four different spiritual competences can be listed, allowing the expected flexibility for later cultural adaptations, since the concept of spirituality can change according to religion, culture, pluralistic societies, historical period and personal perspectives[7,8].

The concept of spirituality expressed in the interviewees' narratives contemplates the essential nuclei cited in the literature[4–9]. In the present study, the concept of spirituality adopted is that used by the European Association for Palliative Care, the same used in the standards of the aforementioned guideline[7]. It is an exclusively human characteristic, which refers to the possibility of transcending reality in search of the sacred and/or of putting oneself in touch with deeper questions of human questioning: re-signifying oneself, seeking and expressing the meaning and purpose of life, one's relationship with the world, with nature and with the sacred[7].

Spirituality is not a field that belongs to a particular institution or religious concept, although it is also intrinsic to religion. Thus, the possibility of providing spiritual care does not depend on nursing professionals sharing the same beliefs as patients[4–6,25–27]. To clarify this issue, it is important to understand that religion concerns a set of beliefs, values and practices that define an aspect of the path to reach faith, the sacred, the divine and God and that generally brings a moral code of conduct , which aims to bring closer and facilitate access to the divine[6,28]. Religiosity, in turn, is a personal characteristic, being the expression of a believer's

spirituality, and therefore it also adds a sense of reflection on human existence, the sacredness of life and dogmas specific to the knowledge of each religious institution[6–8]. Religiosity is, then, a believer's communication channel with their spiritual dimension.

This gap in the education of nursing professionals can suggest other problems, for example, the incipient understanding of the difference between the concepts of spirituality, religiosity and religion[8,28]. In fact, these concepts have similarities. However, full knowledge of them is necessary for ensuring a holistic health care, in order to avoid inaccuracies and malpractices, mainly related to religious beliefs or even their absence.

Despite the essential influence exercised by conceptual understanding and spiritual awareness on the construction of spiritual competences in nursing, it is expected that nurses' reservoir of knowledge on the subject comes from their professional training[24,25]. Corroborating studies that describe the precarious teaching of spirituality in Nursing[6–9], only five of the 14 professionals interviewed reported having had contact with the subject during their training.

The development of pedagogical projects for Nursing courses in Brazil is based on the NCG[11], proposed in the beginning of the century. These guidelines are outdated in what concerns the need to train nursing professionals who are truly critical and contemporary with the discussions around the praxis in health[24]. Regarding spiritual care and spirituality, studies have shown that the topic has been approached in an incipient way both in undergraduate and graduate courses, when approached. This knowledge gap has been minimized through additional education and the movement generated by academic Leagues, whose participation in health education broadens discussions on the subject. In Brazil, so far, there are 61 health spirituality leagues[27].

Professional experience, religious practice and personal aptitude may have filled the educational gap experienced by the professionals participating in this study. In addition to preparation in training, these characteristics can influence nursing professionals in the perception and provision of spiritual care[24]. Studies discuss several factors that predispose to spiritual care in Nursing, such as: length of experience in the profession, professional religious/spiritual values and beliefs, perception of transcendence, self-knowledge, religious affiliation, professional commitment, sensitivity, intentionality and organizational culture[4–8,24–26]. However, there is still no evidence of how much these factors influence nursing professionals regarding the understanding of spirituality and the practice of spiritual patient care[8,28].

The testimonies show lack of preparation in professional education, directly impacting the scientific understanding of spirituality and their daily practice of nursing care. As their professional education was insufficient, nursing professionals provide spiritual care based on their own religious beliefs, which leads them to a practice that is not based on evidence, reducing the uniqueness of the assisted person's principles and values to the professional's spiritual practices.

Professional ethics, often mentioned during the narratives, continue to promote religious impartiality and respect for the autonomy and uniqueness of the spiritual expression of the individuals assisted. This fact corroborates the narratives of nursing professionals also reported in a Brazilian study, which aimed to build a model of spiritual care for patients and family members during illness[5]. The referred study demonstrated that the practices of nursing professionals concerning the spiritual dimension were associated to the ethical duties of conduct and to the social obligation of helping others in need.

This characteristic is accurately described in the AACN Code of Ethics for Nurses[2], one of the first codes that cite the ethical responsibility of nurses regarding spiritual care. In addition to the AACN, other professional entities and associations have also included guidelines that value the practice of compassionate and respectful nursing in the face of people's spirituality in their codes of ethics[2–7]. The professional nursing code of ethics in Brazil was recently updated, but it only included the spiritual field with regard to nursing care in the palliative care scenario[1]. Therefore, in view of the reports shared, the absence of a body of knowledge about spirituality and nursing practice is evident. Ethical precepts guide the practice. However, without knowledge, practice takes us back to scientific disbelief.

According to the international literature, disciplines that prepare nurses and other health providers to provide spiritual care must be longitudinally inserted in the entire mandatory curriculum. The permanent education of the healthcare team is also advocated here in order to maintain the continuous development of this competence. As for the most effective teaching-learning strategies, those focused on self-reflection, group reflection, case discussion or realistic simulation are recommended, as well as work in multidisciplinary teams[25,28]. A Brazilian study reports that related strategies can even help promote the students' comprehensive health, by reducing negative emotions, specifically fear and hostility[27].

Regarding the training process of generalist nurses and NTs in Brazil, the NCG[11] determine that all nurses must attend schools with humanistic, critical and reflective training, not

mentioning specificity that includes training in the spiritual dimension for practice of Nursing, which is why the scope and standards of Nursing practices in Intensive Care defined by the AACN were considered in the present study[2]. Corroborating these specifications, the professional profile of intensive care nurses also follows the humanistic, critical and reflective characteristics of the NCG[11], as well as emphasizing the vision of holistic nursing practice in intensive care, supporting their assistance on an individual-centered care[2].

Despite the great and challenging technical-scientific complexities of critical patients, intensive care Nursing professionals must be able to understand the multi-dimensionalities and singularities of individuals, their families and support networks, recognizing the spiritual dimension as an inherent part of nursing care[2–5]. Nursing organizations in Brazil do not have guidelines that regulate the expected profile for intensive care nurses or nursing technicians.

When caring for a critically ill patient, the nursing team must be highly qualified to meet the basic biological needs, but also to detect early physiological changes and have the necessary knowledge and skills to maintain and interpret all the technological apparatus that helps in keeping the that person's life[4,9,29]. In this context, many people admitted to the ICU need constant surveillance and may be under potentially life-threatening pathological conditions[26,29]. This scenario of hospitalization favors the emergence of significant distress in patients and their families, and it is often up to nursing professionals to promote the first professional health care, in addition to performing the primary task of guaranteeing the patient a quiet place where they feel completely at ease[9].

Complex and heterogeneous demands of a seriously ill patient are often met by professionals impacted by work overload, an architectural arrangement that does not favor the privacy of patients and family members and an organizational culture that does not contemplate spiritual urgency as a care priority[4–9]. These factors, added to the lack of professional training, make it difficult to offer holistic care. Promoting holistic nursing care in the intensive care setting is a multidisciplinary task, but above all, it must be ensured by the values adopted by the hospital institution[7,9].

It is understood that a nursing team properly sized to meet the demands associated with the human complexity and vulnerability of patients and family members during hospitalization can promote safety and effective care, in addition to directly impacting costs, reducing unnecessary procedures, length of stay, readmissions and mortality rates[6,9,29]. These positive outcomes are also mentioned when spiritual care is provided, associated with decrease in pain, better coping with suffering and, consequently, a better quality of life[9].

FINAL CONSIDERATIONS

This study made it possible to describe and analyze the training of nursing professionals to care for the spiritual dimension of critically ill patients. The spiritual nursing care described here is based on the cultural and personal beliefs of the professionals, as well as on the values disseminated in the institution. Part of these results may be related to the fact that the topic was rarely addressed during the training of nursing professionals.

Specifically regarding the role of nurses and NTs in spiritual care in the ICU, lack of technical-scientific preparation was observed. However, this factor was not decisive and, despite the hectic care routine of the sector, the perception and empathy of each nursing professional interviewed ensured care for the spiritual dimension of the people cared for.

Unfortunately, as the subject is not included the curriculum, the nursing practice in the spiritual dimension of critically ill patients described in this study is not based on scientific evidence, reproducing care based on conceptual conflicts and the religious choice of the caregiver. Given the strong ethical background of healthcare professions, the performance of the Nursing team is supported when it guarantees respect for the uniqueness and autonomy of the individuals assisted. The findings of this study can guide decision-making in the management of spiritual nursing care, which is based on the connection between patient and provider above all, promoting health and well-being. The results may also indicate to health corporations the relevance of promoting permanent education and institutionally valuing technical preparation to deal with the spirituality of the individuals who seek health care.

In teaching and at the organizational level, it is imperative to discuss and implement new values in care, guaranteeing comprehensive care that considers the trajectory of users of health services and not just their illness and hospitalization. Knowing, respecting and providing the resources used by people to face adversities is not only offering an assertive and safe service, but also guaranteeing dignity to human life.

A limitation of this study is the fact that only nurses and NTs from the ICUs of a single hospital participated, and therefore, generalizations cannot be made. Further research could investigate the training of nursing professionals to provide care for the spiritual dimension of critical patients in the most diverse hospitalization scenarios, in order to expand theoretical and practical perceptions around spiritual nursing care.

REFERENCES

1. Conselho Federal de Enfermagem (BR). Resolução Cofen n° 564 de 6 de novembro de 2017. Aprova o novo Código de Ética dos Profissionais de Enfermagem. Diário Oficial União. 2014 jan 28 [cited 2022 Jan 11];154(233 Seção 1):157. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=06/12/2017&jornal=515&pagina=157&totalArquivos=164
2. American Association of Critical Care Nurses. AACN Scope and standards for acute and critical care nursing practice. Aliso Viejo, CA; AACN; 2015 [cited 2021 Jan 17]. Available from: https://my.pba.edu/ICS/icsfs/scopeandstandardsacutecriticalcare2015.pdf?target=52a93384-d0fd-40c7-8c20-d26d41c3f1d
3. Riegel F, Crossetti MGO, Martini JG, Nes AAG. Florence Nightingale's theory and her contributions to holistic critical thinking in nursing. Rev Bras Enferm. 2021;74(2):e20200139. doi: http://doi.org/10.1590/0034-7167-2020-0139
4. Badanta B, Rivilla-GarcíaE, Lucchetti G, Diego-Cordero R. The influence of spirituality and religion on critical care nursing: an integrative review. Nurs Crit Care. 2022;27(3):348-66. doi: https://doi.org/10.1111/nicc.12645
5. Góes MGO, Crossetti MGO. Developing a spiritual care model for patients and their relatives in illness. Rev Gaúcha Enferm. 2020;41(spe):e20190150. doi: https://doi.org/10.1590/1983-1447.2020.20190150
6. Thiengo PCS, Gomes AMT, Mercês MCC, Couto PLS, França LCM, Silva AN. Espiritualidade e religiosidade no cuidado em saúde: revisão integrativa. Cogitare Enferm.2019;24:e58692. doi: http://doi.org/10.5380/ce.v24i0.58692
7. van Leeuwen R, Attard J, Ross L, Boughey A, Giske T, Kleiven T, et al. The development of a consensus-based spiritual care education standard for undergraduate nursing and midwifery students: an educational mixed methods study. J Adv Nurs. 2021;77(2):973-86. doi: https://doi.org/10.1111/jan.14613
8. Cooper KL, Luck L, Chang E, Dixon K. What is the practice of spiritual care? a critical discourse analysis of registered nurses' understanding of spirituality. Nurs Inq. 2021;28(2):e12385. doi: https://doi.org/10.1111/nin.12385
9. Riahi S, Goudarzi F, Hasanvand S, Abdollahzadeh H, Ebrahimzadeh F, Dadvari Z. Assessing the effect of spiritual intelligence training on spiritual care competency in critical care nurses. J Med Life. 2018;11(4):346-54. doi: https://doi.org/10.25122/jml-2018-0056
10. Hawthorne DM, Gordon SC. The invisibility of spiritual nursing in clinical practice. J Holist Nurs. 2020;38(1):147-55. doi: https://doi.org/10.1177/0898010119889704
11. Ministério da Educação (BR). Conselho Nacional de Educação. Câmara de Educação Superior. Resolução nº 3, de 7 de novembro de 2001. Institui diretrizes curriculares nacionais do curso de graduação em enfermagem. Diário Oficial União. 2001 nov 9 [cited 2022 Jan 26];138(215 Seção 1):37-8. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=09/11/2001&jornal=1&pagina=37&totalArquivos=160
12. Wermelinger MCMW, Boanafina A, Machado MH, Vieira M, Ximenes Neto FRG, Lacerda WF. Nursing technician training: qualification profile. Ciênc Saúde Colet. 2020;25(1):67-78. doi: https://doi.org/10.1590/1413-81232020251.27652019
13. Meihy JCSB, Seawright L. Memórias e narrativas: história oral aplicada. São Paulo: Contexto; 2020.
14. Holanda F, Meihy JCSB. História oral: como fazer, como pensar. 2. ed. São Paulo: Contexto; 2007.
15. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial União. 2013 jun 13 [cited 2022 Jan 26];150(112 Seção 1):59-62. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=13/06/2013&jornal=1&pagina=59&totalArquivos=140
16. Souza VRS, Marziale MHP, Silva GTR, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm. 2021;34:eAPE02631. doi: http://doi.org/10.37689/actaape/2021AO02631
17. Universidade Federal de São Paulo. Hospital São Paulo [Internet]. Atendimento Hospitalar. São Paulo: Hospital São Paulo; 2021 [cited 2022 Feb 3]. Available from: https://www.hospitalsaopaulo.org.br/atendimento-hospitalar.html
18. Marre JL. História de vida e método biográfico. Cad Sociol. 1991;3(3):89-141.
19. Ozdemir NG. The development of nurses' individualized care perceptions and practices: Benner's novice to expert model perspective. Int J Caring Sci: 2019 [cited 2022 Feb 10];12(2):1279-85. Available from: http://www.internationaljournalofcaringsciences.org/docs/81_ozdemir_special_12_2.pdf
20. Presidência da República (BR). Secretaria-Geral. Subchefia para Assuntos Jurídicos. Lei nº 13.709, de 14 de agosto de 2018. Dispõe sobre a proteção de dados pessoais e altera a Lei nº 12.965, de 23 de abril de 2014 (Marco Civil da Internet). Diário Oficial União. 2018 ago 15 [cited 2022 Feb 10];155(157 Seção 1)59-64. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=15/08/2018&jornal=515&pagina=59&totalArquivos=215
21. Bardin L. Análise de conteúdo. 70. ed. São Paulo: Almedina Brasil; 2016.
22. Conselho Federal de Enfermagem (BR). Fundação Oswaldo Cruz. Perfil da enfermagem no Brasil: relatório final [Internet]. Rio de Janeiro: COFEN, FIOCRUZ; 2017 [cited 2021 Feb 19]. Available from: http://www.cofen.gov.br/perfilenfermagem/pdfs/relatoriofinal.pdf
23. Instituto Brasileiro de Geografia e Estatística (BR) [Internet]. Censo Brasileiro de 2010. Panorama da cidade de São Paulo. Rio de Janeiro: IBGE; 2012 [cited 2021 Feb 23]. Available from: https://cidades.ibge.gov.br/brasil/sp/sao-paulo/panorama
24. Akça SO, Gülnar E, Özveren H.Spiritual care competence of nurses. J Contin Educ Nurs. 2022;53(5):225-31. doi: https://doi.org/10.3928/00220124-20220407-05
25. Rykkje L, Søvik MB, Ross L, McSherry W, Cone P, Giske T. Educational interventions and strategies for spiritual care in nursing and health care students and staff: a scoping review. J Clin Nurs. 2022;31(11-12):1440-64. doi: https://doi.org/10.1111/jocn.16067
26. Santos PM, Rodrigues KS, Pinheiro LA, Santana BS, Ipólito MZ, Magro MCS. Religious and spiritual support in the conception of nurses and families of critical patients: a cross-sectional study. Rev Esc Enferm USP. 2021;55:e20200508. doi: https://doi.org/10.1590/1980-220X-REEUSP-2020-0508
27. Oliveira LAF, Oliveira AL, Ferreira MA. Formação de enfermeiros e estratégias de ensino-aprendizagem sobre o tema da espiritualidade. Esc Anna Nery. 2021;25(5):e20210062. doi: https://doi.org/10.1590/2177-9465-EAN-2021-0062
28. Lalani N. Meanings and interpretations of spirituality in nursing and health. Religions. 2020;11(9):428. doi: https://doi.org/10.3390/rel11090428
29. Abuejheisheh A, Tarawneh O, Qaddumi JAS, Almahmoud O, Darawad MW. Predictors of intensive care unit nurses' practice of evidence-based practice guidelines. Inquiry. 2020;57;46958020902323. doi: https://doi.org/10.1177/0046958020902323

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