

# Spiritual care provided by the nursing team to the person in palliation in intensive care



*Cuidado espiritual prestado pela equipe de enfermagem à pessoa em palição na terapia intensiva*  
*Cuidado espiritual proporcionado por el equipo de enfermería a la persona en paliación en cuidados intensivos*

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## ABSTRACT

**Objective:** To understand how the spiritual care provided by the nursing team to the person undergoing palliation in the Intensive Care Unit occurs.

**Method:** Study with a qualitative approach, conducted in an Intensive Care Unit in Salvador, Bahia. Data collection took place through semi-structured interviews between January and May 2019. 14 nurses and 21 nursing technicians participated in the study. The data were submitted to Bardin Content Analysis and analyzed in the light of the Peaceful End of Life Theory.

**Results:** Two categories emerged: 1. Spiritual care provided through words of optimism, encouragement of faith and prayer; 2. Care provided through attention to spiritual needs and assurance of comfort.

**Final considerations:** Although empirically and not aware of the spiritual care provided, the nursing team offers support with words of optimism, faith, moments of prayer and contributes to the spiritual comfort of the person in palliation.

**Keywords:** Nursing. Spirituality. Hospice care.

## RESUMO

**Objetivo:** Aprender como ocorre o cuidado espiritual prestado pela equipe de enfermagem à pessoa em palição na Unidade de Terapia Intensiva.

**Método:** Estudo de abordagem qualitativa, realizado em uma Unidade de Terapia Intensiva em Salvador, Bahia. A coleta de dados ocorreu por entrevistas semiestruturadas entre janeiro e maio de 2019. Participaram do estudo 14 enfermeiras e 21 técnicas de enfermagem. Os dados foram submetidos à Análise de Conteúdo de Bardin e analisados à luz da Teoria Final de Vida Pacífico.

**Resultados:** Emergiram duas categorias: 1. Cuidado espiritual prestado através de palavras de otimismo, estímulo a fé e oração; 2. Cuidado prestado através da atenção às necessidades espirituais e da garantia de conforto.

**Considerações finais:** Embora de forma empírica e não consciente do cuidado espiritual prestado, a equipe de enfermagem oferta apoio com palavras de otimismo, fé, momentos de orações e contribui para o conforto espiritual da pessoa em palição.

**Palavras-chave:** Enfermagem. Espiritualidade. Cuidados paliativos na terminalidade da vida.

## RESUMEN

**Objetivo:** Comprender cómo ocurre el cuidado espiritual prestado por el equipo de enfermería a la persona en paliación en la Unidad de Cuidados Intensivos.

**Método:** Estudio con enfoque cualitativo, realizado en una Unidad de Cuidados Intensivos en Salvador, Bahía. La recolección de datos ocurrió a través de entrevistas semiestructuradas entre enero y mayo de 2019. Participaron del estudio 14 enfermeros y 21 técnicos de enfermería. Los datos se sometieron al Análisis de Contenido de Bardin y se analizaron a la luz de la Teoría del Final Pacífico de la Vida.

**Resultados:** surgieron dos categorías: 1. Atención espiritual a través de palabras de optimismo, estímulo de la fe y oración; 2. Atención a través de la atención a las necesidades espirituales y garantía de comodidad.

**Consideraciones finales:** Aunque empíricamente y desconociendo el cuidado espiritual prestado, el equipo de enfermería ofrece apoyo con palabras de optimismo, fe, momentos de oración y contribuye al confort espiritual de la persona en paliativo.

**Palabras clave:** Enfermería. Espiritualidad. Cuidados paliativos al final de la vida.

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## ■ INTRODUCTION

Palliative Care (PC) according to the World Health Organization (WHO), in the concept defined in 1990, and updated in 2002, consists of assistance provided by a multidisciplinary team, which aims to improve the person's Quality of Life (QoL) and their relatives in coping with a life-threatening disease, through the prevention and relief of suffering, early identification, assessment and treatment of pain and other physical, social, psychological and spiritual symptoms<sup>(1)</sup>.

PC can be offered to all people with diseases without therapeutic possibilities, from the initial stage to the end of the cycle. Thus, in hospital environments, whether in the ward or Intensive Care Unit (ICU), multidimensional care for the person must occur uninterruptedly by health professionals<sup>(2)</sup>.

With regard to the provision of care by the nursing team, multidimensional care encompasses the biological, psychological, social and spiritual dimensions; the latter being extremely important in comprehensive care. Therefore, spirituality can be considered as the most urgent dimension in the context of diseases, due to the presence of physical and emotional fragilities developed. In this regard, research conducted in a PC unit showed that adequate spiritual care positively influences the person and family members, given that the experience of the terminal process helps them to face the care process at the end of life<sup>(3)</sup>.

It is understood that the spiritual dimension is consisted by the spirituality and religiosity of the human being, and spirituality does not refer only to the practices of religion; it involves personal and intimate values, brings what boost life and enables personal growth and the re-signification of experiences, guiding the meaning of life. On the other hand, religiosity is the practice of religion, and refers to a set of beliefs, language and dogmatic practices that are based on a religious affiliation, with its symbols, rituals, ceremonies and specific explanations about life and death<sup>(4)</sup>.

It is known that spirituality is capable of helping people in PC to resist physical and psychological pressures and discomforts, promoting determination, resilience and well-being<sup>(5)</sup>. Thus, the spiritual dimension can help everyone involved in the care process to face with more tranquility the complex moments experienced in the course of the disease.

Although there is no consensus on the concept of spiritual care, a study analyzing concepts established in several countries defined spiritual care as a structured process, centered on the patient, considering their understanding of being and existing in the world, allowing the professional to identify problems of a spiritual and/or religious nature that had a stable meaning or had collapsed, and thus, systematize care around these spiritual and religious needs<sup>(6)</sup>.

However, promoting spiritual care within the ICU is a challenging intervention, as it is a sector of the hospital environment designed to promote invasive and curative care for people who are in a serious condition, sometimes on the imminence of death, which distress and frightens those involved, especially those affected by diseases beyond the therapeutic possibility.

In this scenario, it is necessary that the spiritual dimension be contemplated by the nursing team, and included in the care plan<sup>(7)</sup>, in order to promote a state of peace, balance and well-being, suggested by the framework of the Peaceful End of Life Theory (PELT), middle-range theory<sup>(8)</sup>.

In view of the above, it is observed a need for professionals prepared to deal with the challenges experienced by people and their families during hospitalization, especially in the ICU, where there is a predominance of hard technologies, represented by equipment and machines and concrete materials that occupy the hospital environment, which denote the practice of care and the practice of the biomedical model<sup>(9)</sup>.

Although the national and international literature is wide about PC, there is a scarcity of publications on the spiritual care of the nursing team in the ICU, despite the end of life, and in the Brazilian reality, many of these patients are treated in the ICU.

In this context, the following guiding question emerged: How is the spiritual care provided by the nursing team to the person undergoing palliation in the Intensive Care Unit? Therefore, the objective of this research is: To understand how the spiritual care provided by the nursing team to the person in palliation occurs in the Intensive Care Unit.

## ■ METHOD

Descriptive-exploratory study, with a qualitative approach, part of a matrix project entitled: "Performance of the multidisciplinary team in palliative care in the Intensive Care Unit: The Peaceful End of Life Theory".

The research was conducted at the Immunological ICU of a private hospital in the city of Salvador, Bahia, Brazil. 14 nurses and 21 nursing technicians participated in the study. The choice of this professional category was by the profile of professional competences in nursing and the proximity of the area with the object of study.

The unit selected for the study does not have beds for the person in PC, so the inclusion criteria were Nursing professionals with more than one year of experience in caring for PC patients in the ICU, which suggests sufficient time for contact with patients in palliation; and Nursing professionals belonging to the unit's permanent staff. The exclusion criteria were professionals who were on sick leave, characterized by social security, or maternity and vacation.

Data collection took place between January and May 2019, using the inclusion and exclusion criteria, after presenting the objective of the study to the eligible professionals, through an individual face-to-face interview previously scheduled in the morning, afternoon or evening shifts, with an average duration of 15 to 25 minutes.

The instrument for the collection of statements was a semi-structured script, composed of two parts. The first, with characterization data of the participants, and the second one, with eight open questions that sought to answer the object of the study, which were: How have you been taking care of PC patients in the ICU?; Do you find facilities and/or difficulties in caring for PC patients in the ICU?, if so, which ones?; What actions do you perform and consider as belonging to PC in the ICU?; In your opinion, what are the main basic needs of PC patients in the ICU?; When the patient and/or family reports fear and/or anxiety, how do you take care of the emotional aspects?; What actions do you develop so that PC patients are closer to their relatives, friends and/or people who care for them?; How do you communicate with your PC patient in the ICU?; How do you communicate with the multiprofessional team members about the PC patient?.

The statements were collected at the workplace, in a private room. In order to guarantee the use of the information, the speeches were recorded using a digital audio device, and later, transcribed in full. At the end, the recording was presented to each interviewee, for their knowledge and approval. After the clarification about the research objectives, previously to the recordings, the Free Informed Consent Form was presented, for formal authorization of each interviewee's participation. The interviews were ended when data saturation was reached, when new information no longer emerged<sup>(10)</sup>.

After the interviews, the fully transcribed statements were submitted to Bardin Content Analysis technique<sup>(11)</sup>, through the following stages: 1) Pre-analysis, with exhaustive readings of the material and its organization; 2) Material exploration, where the text of the interviews was cut into recording units (words, sentences, paragraphs) and grouped thematically into initial, intermediate and final categories, which made inferences possible; 3) Treatment and interpretation of results, phase in which there was synthesis of the results, condensation of the fundamental elements of a message related to the object of investigation and capture of the latent contents contained in all the material collected. Finally, the data were discussed in light of the PELT concepts<sup>(8)</sup>.

Published in 1998 by nurses Cornelia Ruland and Shirley Moore, the PELT, considered a middle-range theory, aims

to promote QoL to terminally ill people, offering relief from pain, discomfort and anguish; maintenance of hope and meaning; establishment of trust between the patient/family/nurse; respect for the integrity of the patient and the family, emphasizing their right to decision-making; practical guidance on issues that may arise based on the situation that encompasses the death of the patient involved<sup>(8)</sup>.

The study was approved by the Research Ethics Committee, with opinion no.2,890,509 and CAAE 93808218,9,0000,0048. The research complied with the recommendations of Resolutions nº 466/12 and nº 510/16 of the National Health Council. To ensure anonymity, all interviews were coded, using the letters "N" corresponding to Nurse and "NT", Nursing Technician, followed by the order number of the interviews in each category.

## ■ RESULTS

Thirty-five nursing professionals participated in the study, being 14 nurses and 21 nursing technicians. From these, 27 are female and eight are male. This data shows the predominance of females among nursing professionals, arising from the historical relationship between the female figure and the provision of care. The age group ranged between 23 and 53 years.

As for the postgraduate course in the ICU, 13 nurses had a specialization, and one had a residency in oncology. It is noteworthy that all participants had already worked with people under critical care and in palliation, no technical professional had an update and/or extension course in correlated area.

Regarding religion, 20 participants stated to be Catholics, eight Evangelicals, three Spiritualists, one Jehovah's Witness and three reported having no religious affiliation. Regarding the time of work in the ICU, there was a variation from two to 28 years of experience.

The study is innovative, as it brings results from interviews with nurses and nursing technicians who experience the routine in the Intensive Care Unit with PC and can contribute to the insertion of spiritual care into the practice of the nursing team in assisting this patient profile of hospitalized people, who often bring such demand.

After the analysis of the statements, the following thematic categories emerged: 1. Spiritual care provided through words of optimism, encouragement of faith and prayer; and, 2. Care provided through attention to spiritual needs and assurance of comfort.

## 1. Spiritual care provided through words of optimism, encouragement of faith and prayer

When the person hospitalized in the ICU and/or their relatives report fear and/or anxiety, the participants use spirituality through faith and words of optimism to offer welcoming and spiritual care, as statements shown below:

*[...] I try to talk, right? In my own way as a professional, I try to pass on to him something of a message of faith, to does not forget that God exists. (NT01)*

*You often must give your patient a Peace of Mind, talk to him about God, because you don't necessarily need to be Catholic, religious to talk about God, you know, Faith is within each of us, you just must have and believe. I try to do it this way. (NT19)*

*I try to take it to the religious part, that's what I do. I try to hug that person who is showing to be afraid, and I try to take it to the religious part, I always ask, if what they believe regardless of their religion: Candomblé, Catholic, apostolic, but if he believes in God, we will think together here, right? Hope it's the best for the patient. (N01)*

Faced with the fear and anxiety presented by people and relatives, the nursing team offers spiritual care through practices such as shared prayers.

In this way, it is observed that this public experiences valuable moments and strengthens the bonds between the social actors involved, as can be seen in the following statements.

*[...] I welcome the whole family, if the family wants to say a prayer, a farewell, I've been through several moments like this, I welcome the moment, I talk, I offer my ear, yeah, we listen a lot, listen more than talk at this moment..." (N06)*

*I stand by the family with a word of support, and I allow myself to participate when they want to say a prayer, so I try to supply that, then I think I can meet the emotional aspects [...]. (N11)*

*I speak of God, I say surrender to him and wait, have faith. If they like to pray, I pray with them too, I always try to say positive things, I think it helps. (NT11)*

For the person who is facing moments of pain, anxiety, emotional challenges, welcoming through spirituality can enable them to find the meaning of life in the face of the difficulties involved in the care process, as reported below by the participants:

*I speak of comfort, of God so that they ask for strength, but spirituality, which in these cases is very important, patients cling to God to spiritualism, I try to enliven the environment, I talk about other things [...]. (NT13)*

*When I notice that the patient is anxious, afraid of the treatment, I try to say positive words, I usually try to find out if he/she is religious and belongs to which religion, if he/she is a Christian, if so! so pray, cry and ask God that everything will be ok, believe, have faith. It's at that moment that you pass your positivity, I believe you touch a little bit. (NT16)*

*I talk to the person trying to calm them down, try to pass on positive words and try to show that the situation is transitory. (NT17)*

*I try to welcome, talk a little, I speak words of faith [...] I listen to what they say. (N10)*

## 2. Care provided through attention to spiritual needs and assurance of comfort

When asked about the most important actions of PC, participants commented that the team sometimes cannot address spirituality, which is subjective and hard to access, although they recognize that it is important for care, as it provides comfort. In this regard, one participant confirms that pain can go beyond the physical, by mentioning "spiritual pain", and can be recognized through the creation of a bond and trust with the person in PC.

*I think we don't do palliative care in the ICU [...] because we don't do it, we don't work on the social part, we can't, we weren't prepared to work on the spiritual part of the patient. I try to get a little closer, try to create a bond with the patient [...] to give a little more comfort, but you work on this part of the spiritual pain, the other issues related to what we cannot visualize the subjective, it is very difficult, I try to create a bond with the patient first. (N05)*

*Faced with these patients, I try to provide comfort, to be attentive so that they do not feel pain, always be comfortable, well-being, that they stay in peace. (NT15)*

*I try to pass on trust, I say to have faith in God. (NT20)*

Religiosity, inserted in the spiritual dimension, also demarcated its relevance for professionals as benefits for the person who experiences a disease without therapy, and once again, the participants understand the spiritual dimension as a therapeutic resource and a possibility to provide

comfort, as it strengthens and supports, as observed in the following statements:

*In my opinion, what this patient needs most is comfort, because he/she is already suffering, so I surrender him to God and try to provide good care [...]. My actions are always to encourage them to bring a book that the patient likes or even the bible if they are religious and read to them, so I try to take them to this religious side because they feel more relieved, both the relatives and the patient. (NT11)*

*We, for example, do not ask if they need a visit from a preacher or a visit from a spiritual leader. I think this ends up leaving much to be desired. (N11)*

*[About the important actions for PC]. I think it's spirituality, when the patient is already aware of terminality, some patients today already show it, and then what can I do to stay within my budget. (N14)*

The statements above also reinforce that the person under hospice care also moves the participants internally, which reinforces their empathy and religious respect, showing that care beyond the physical is necessary, possible and emerging, thus considering the person and not the disease.

Reinforcing that through religiosity and spirituality it is possible to offer comfort to the person in PC, there was also a report about the professional's spirituality and belief as a positive factor for understanding the beneficial results of the reported dimension, and even understanding about life and death.

*The spiritual part. Since it goes according to my basic precept of religion, as I am a person who has a religious base in Christianity, and I think there is a process of death and that this person at the end of life, will be going through another spiritual plane, so I think providing him/her with a realization of this end of life to another spiritual plane is the main thing. (N14)*

*I like to talk, when he/she is lucid I ask about the family, I talk about my children. Sometimes I even talk about religion. There are some who like it, and they start to vent, especially at the time of the bed bath that takes a little longer, I do everything to make them feel comfortable and talk about whatever they want. (NT10)*

## ■ DISCUSSION

The study participants report that they use words of support and encouragement of faith in God, to promote comfort to the person and relatives in periods when fear appears together with the will to live. These attitudes show a sensitivity of professionals to deal with the pain of the other, thus signaling for a comprehensive care based on the value of the human dimension, which transcends the physical.

A study conducted in a hospital in Paraíba corroborates the findings, and infers that faith and hope are pointed out by nursing professionals as spiritual needs found in people in PC. Therefore, it is understood that faith is capable of contributing to the development of trust and strength of the person to cope with and directly reflects on the improvement of their condition, even in the face of a process of finitude<sup>(5)</sup>.

In addition to the support offered by nursing professionals through the development of the practice of faith, participants brought that belief in religions can help people in palliation and relatives, as it provides comfort in the face of the unexpected experience of illness and proximity to death, being the awakening of faith a source of growth, strengthening, regeneration or evolution<sup>(12)</sup>.

Therefore, the testimonies of nurses and technicians reflect that health professionals use the religiosity, spirituality and faith of each person to promote comfort. Such attitudes corroborate with the PELT with regard to one of its pillars about the quest to promote a state of peace, which is to provide the person with tranquility in the physical, psychological and spiritual aspects<sup>(7,13)</sup>. In this context, the care of the nursing team can minimize distress and provide support so that the moment of finitude becomes less painful.

Participants reported that, to promote the state of being peaceful and experiencing the comfort of the soul, prayers and connections with the sacred can be stimulated in people under PC in the ICU. Therefore, the results found in the study are in line with what the PELT proposes<sup>(8)</sup>.

When the participants signal their availability to perform prayers together with the person in PC and relatives, respecting each one's beliefs, they believe they are promoting spiritual care. In this regard, people with diseases without therapeutic possibilities manifest the need to experience their religious beliefs and the permission and support of the health team within the possibilities and routine religious practices in the hospital environment<sup>(5)</sup>.

Some participants reported that stimulating spirituality and religiosity is important and promotes comfort and well-being for the sick person. A study conducted with a multiprofessional team showed that all professionals reported comfort as an essential element of PC in the ICU<sup>(14)</sup>. In this regard, the PELT proposes that the person experience comfort, which is called relief from discomfort, the state of ease and peaceful contentment, which makes life easier or more pleasant<sup>(8)</sup>.

In agreement, the study shows that words of comfort and optimism are seen by nursing professionals as spiritual care, as it is a need that feeds the soul and strengthens the person in the face of adversity<sup>(5)</sup>. In another study, professionals reported that, through spirituality, it is possible to offer comfort in the care of people in PC<sup>(15)</sup>.

The spiritual needs of terminally ill patients and their families are poorly recognized and addressed in the ICU, where the biological dimension, technology and efficiency are focused. However, the ICU is potentially a promising scenario to reflect on experiences and boost expressions of spirituality<sup>(16)</sup>.

With the statements of the participants, it was possible to observe the need to prepare the nursing team to address the issue in clinical practice, so that it is possible to offer comprehensive, specialized, sensitive, and meaningful care for the patient-family binomial. Studies indicate that spiritual needs have an outstanding value in the care of the person in PC, since their identification allows health professionals to help them face the process of bereavement and mourning<sup>(3)</sup>.

A study in South Korea finds that considering people to be spiritual beings (whether religious or not) can be one of the strongest predictors to the nursing team in providing spiritual care for people with life-threatening illnesses. Thus, spiritual care should emphasize the identification and response to the needs of the human spirit, including aspects of spirituality through a compassionate relationship with the person in PC<sup>(17)</sup>.

Thus, with the statements of the participants, it is understood that nursing has the potential to offer spiritual care but needs to include such approach in its daily practice, especially when this care is directed to people in PC. The participants' perception of the practices of prayers, reading and spiritual strengthening in the PC corroborates the concepts of the PELT, which suggests the identification of the basic needs of each person to build a care plan, based on scientific evidence, aimed at the promotion of comfort<sup>(8)</sup>.

Participants also reported the difficulty in welcoming people in PC when they observe the need for subjective care, which transcends the physical. They reported that, sometimes, they do not provide spiritual care to the person

and their relatives because they do not feel prepared to solve such a demand, although they recognize the importance of the spiritual dimension in PC, above all, the need for religious practice, either through personal practice and/or visit by religious leaders.

The distancing of the participants is a factor that interferes with care and can be associated with the denial of finitude, because, when experiencing the process of death and dying, especially when reporting to a young person, the participants find themselves unprepared to recognize their professionals limitations and say goodbye to people of a younger age group, especially in the ICU, where the curative model and the presence of hard technologies in the care process predominate. Corroborating this, a study finds that, although death is part of the hospital routine, there is still a resistance to talking about the subject on the part of health professionals<sup>(18)</sup>.

A study showed that the spiritual issues of the person in PC are facilitated by their belief about death and their religiosity, showing that the professional who cannot deal with their own spiritual dimension will have more difficulty in dealing with the death of the other and, possibly, will move away from this care, manifesting this in the fragmentation of the human being, with an emphasis on the biological, or referring to it through their disease or physical symptoms<sup>(14)</sup>.

The participants commented that it is difficult for the person and their relatives to know about the condition of proximity to death and stated that this feeling also permeates among them. Such speeches draw attention to the need for emotional attention and spiritual support and reinforce that the team needs to develop the routine of a sensitive look, in addition to physical care, with support for the family, which may experience suffering, and in this process of anguish ask for answers and even hope for a cure.

In this sense, it is important that the nursing team is sensitized to stimulate the practice of spirituality in PC, recognizing that it has a range of different meanings for the person, including responding to questions about their own existence. Understanding this, nursing professionals who work in PC can give more meaning to their work process in this theme, as they deal with the terminality of the other and prepare for a good death<sup>(14)</sup>. Thus, it is necessary that health professionals recognize and value the dimension of the spiritual care of the being as a tool to promote comfort to people in PC.

Comfort, associated with pain relief, approximation with loved ones, promotion of dignity and respect, in addition to the experience of peace are concepts of PELT, which are similar to the principles of palliative care<sup>(12)</sup>.

In this way, it is emphasized that caring for people in situations close to death requires more than scientific and technical knowledge, it requires an understanding of the unique aspects of the person cared for, consideration of subjective, ethical, social and cultural issues, and habits that promote being at peace in all its dimensions<sup>(19)</sup>, in accordance with the PELT<sup>(8)</sup>.

Spirituality is a term that denotes several meanings. For this reason, it can make it difficult for professionals to meet the spiritual needs of ill people, as well as the production of adequate tools that can assess the spiritual and religious issues of those under palliative care.

## ■ FINAL CONSIDERATIONS

The study showed that the nursing team offers spiritual care with words of optimism, faith, moments of prayer, enabling to strengthen the link between the team, person in PC and family, with this dimension of care providing peace, tranquility and balance of some people and family members, while facing life-threatening situations, with serenity and resilience.

Despite welcoming the person in PC and relatives, the study found that professionals recognize the importance of the spiritual dimension in the care process but show fear and reveal difficulties when faced with finitude, evidencing the fragility of some professionals to offer this care to the person with a life-threatening illness.

Regarding the limitations of this study, it is stated that it was conducted in a single hospital, which may not correspond to the realities experienced in other places, thus highlighting the need to expand studies on the subject in other ICU care settings, to be possible to strengthen the multiplication of knowledge about spiritual care for people in peaceful end of life care.

In the light of the PELT, it is observed that comfort was associated as a possibility through spirituality and religiosity to promote a peaceful end of life and awakens to the possibility of rescuing nursing care based on theories.

Given the above, it is relevant that professionals from the nursing team are able to promote spiritual care, with its insertion in the nursing process and systematization of care, since for the practice of comprehensive care it is necessary to consider the multiple dimensions of being biopsychosocial-spiritual human.

In teaching, it is believed that the fundamentals and practices associated with spiritual care can be incorporated into the curriculum of all areas of knowledge, especially

nursing, so that safer professionals are trained for care that goes beyond the physical.

For the service management, the study indicates that competences, training and assessment tools must be developed, in the search to contribute to the expansion of knowledge among health care professionals about the need for spiritual care, in order to provide comprehensive care to the person in PC. Finally, further studies are suggested with the application of PELT in the care for the person who experiences the illness without therapeutic possibilities and their family members.

## ■ REFERENCES

1. World Health Organization [Internet]. Geneva: WHO; 2017 [cited 2021 Dec 8]. WHO definition of palliative care. Available from: <http://www.who.int/cancer/palliative/definition/en/>.
2. Coelho CBT, Yankaskas JR. New concepts in palliative care in the intensive care unit. *Rev Bras Ter Intensiva*. 2017;29(2):222-30. doi: <https://doi.org/10.5935/0103-507X.20170031>.
3. Crize LB, Noguez PT, Oliveira SG, Bezerra BCC. Espiritualidade no cuidado de enfermagem ao paciente oncológico em cuidados paliativos. *Salusvita*. 2018 [cited 2021 Dec 6];37(3):577-97. Available from: [https://secure.unisagrado.edu.br/static/biblioteca/salusvita/salusvita\\_v37\\_n3\\_2018/salusvita\\_v37\\_n3\\_2018\\_art\\_08.pdf](https://secure.unisagrado.edu.br/static/biblioteca/salusvita/salusvita_v37_n3_2018/salusvita_v37_n3_2018_art_08.pdf).
4. Freitas RA, Menezes TMO, Santos LB, Moura HCGB, Sales MGS, Moreira FA. Spirituality and religiosity in the experience of suffering, guilt, and death of the elderly with cancer. *Rev Bras Enferm*. 2020;73(Suppl 3):e20190034. doi: <https://doi.org/10.1590/0034-7167-2019-0034>.
5. Evangelista CB, Lopes MEL, Costa SFG, Abraão FMS, Batista PSS, Oliveira RC. Spirituality in patient care under palliative care: a study with nurses. *Esc Anna Nery*. 2016;20(1):176-82. doi: <https://doi.org/10.5935/1414-8145.20160023>.
6. Nissen RD, Viftrup DT, Hvidt NC. The process of spiritual care. *Front Psychol*. 2021;12:674453. doi: <https://doi.org/10.3389/fpsyg.2021.674453>.
7. Tavares AL, Devezas AMLO, Reppetto MA, Santos LSC. Atenção do enfermeiro em relação a espiritualidade no cuidar do paciente em unidade de terapia intensiva. *Rev Recien*. 2020 [cited 2021 Dec 6];10(30):62-7. Available from: <https://recien.com.br/index.php/Recien/article/view/265>.
8. Ruland CM, Moore SM. Theory construction based on standards of care: a proposed theory of the peace full end of life. *Nurs Outlook*. 1998;46(4):169-75. doi: [https://doi.org/10.1016/s0029-6554\(98\)90069-0](https://doi.org/10.1016/s0029-6554(98)90069-0).
9. Souza NS, Souza TSB, Chagas FRC, Silva NF, Silva SV, Silva CC. Repercussions of care technologies in intensive care units. *J Nurs UFPE online*. 2018;12(10):2864-72. doi: <https://doi.org/10.5205/1981-8963-v12i10a236449p2864-2872-2018>.
10. Nascimento LCN, Souza TV, Oliveira ICS, Moraes JRMM, Aguiar RCB, Silva LF. Theoretical saturation in qualitative research: an experience report in interview with schoolchildren. *Rev Bras Enferm*. 2018;71(1):228-33. doi: <http://doi.org/10.1590/0034-7167-2016-0616>.
11. Bardin L. *Análise de conteúdo*. São Paulo: Edições 70; 2016.

12. Barbosa RMM, Ferreira JLP, Melo MCB, Costa JM. A espiritualidade como estratégia de enfrentamento para familiares de pacientes adultos em cuidados paliativos. *Rev SBPH*. 2017 [cited 2021 Dec 5];20(1):165-82. Available from: <http://pepsic.bvsalud.org/pdf/rsbph/v20n1/v20n1a10.pdf>.
13. Zaccara AAL, Costa SFG, Nóbrega MML, França JRFS, Morais GSN, Fernandes MA. Analysis and assessment of the peaceful end of life theory according to Fawcett's Criteria. *Texto Contexto Enferm*. 2017;26(4):e2920017. doi: <https://doi.org/10.1590/0104-07072017002920017>.
14. Pires IB, Menezes TMO, Cerqueira BB, Albuquerque RS, Moura CGB, Freitas RA, et al. End-of-life comfort in intensive care: the perception of the multidisciplinary team. *Acta Paul Enferm*. 2020;33:eAPE20190148. doi: <http://doi.org/10.37689/acta-ape/2020A00148>.
15. Arrieira ICO, Thofehr MB, Porto AR, Moura PMM, Martins CL, Jacondino MB. Spirituality in palliative care: experiences of an interdisciplinary team. *Rev Esc Enferm USP*. 2018;52:e03312. doi: <http://doi.org/10.1590/S1980-220X2017007403312>.
16. Swinton M, Giacomini M, Toledo F, Rose T, Hand-Breckenridge T, Boyle A, et al. Experiences and expressions of spirituality at the end of life in the intensive care unit. *Am J Respir Crit Care Med*. 2017;195(2):198-204. doi: <https://doi.org/10.1164/rccm.201606-11020C>.
17. Kang KA, Kim SJ, Kim DB, Park MH, Yoon SJ, Choi SE, et al. A meaning-centered spiritual care training program for hospice palliative care teams in South Korea: development and preliminary evaluation. *BMC Palliat Care*. 2021;20(1):30. doi: <https://doi.org/10.1186/s12904-021-00718-1>.
18. Perboni JS, Zilli F, Oliveira SG. Profissionais de saúde e o processo de morte e morrer dos pacientes: uma revisão integrativa. *Pers bioét*. 2018;22(2):288-302. doi: <https://doi.org/10.5294/pebi.2018.22.2.7>.
19. Nascimento LC, Oliveira FCS, Santos TFM, Pan R, Flória-Santos M, Alvarenga WA, et al. Atenção às necessidades espirituais na prática clínica de enfermeiros. *Aquichan*. 2016;16(2):179-92. doi: <https://doi.org/10.5294/aqui.2016.16.2.6>.



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