

Difficulties Of Nurses In The Spiritual Care Of The Palliative Person: A Scoping Review

RESUMO | Objetivo: Mapear a evidência científica relativa às dificuldades dos enfermeiros no cuidar espiritual da pessoa em situação paliativa. Método: Estudo do tipo Scoping Review, com base nas recomendações PRISMA-ScR e do protocolo definido pelo Joanna Briggs Institute. Pesquisa em 4 bases de dados: Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), National Library of Medicine (PUBMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL) e Web of Science e considerados estudos dos últimos 5 anos. Resultado: Amostra final de 10 estudos. Foram identificadas várias dificuldades dos enfermeiros no cuidar espiritual da pessoa em situação paliativa, dos quais destacamos: falta de formação; falta de tempo; falta de reconhecimento; falta de confiança; evitamento; referência tardia; espiritualidade dos enfermeiros pouco desenvolvida; crenças diferentes. Conclusão: Foram identificadas múltiplas dificuldades sentidas pelos enfermeiros no cuidar espiritual, as quais passam quer por défices na formação, quer por défices organizacionais, quer por défices pessoais.

Descritores: Cuidados Paliativos; Cuidados de fim de vida; Enfermagem; Espiritualidade; Cuidado Espiritual.

ABSTRACT | Objective: To map the scientific evidence concerning the difficulties faced by nurses in the spiritual care of palliative care patients. Method: Scoping Review, based on PRISMA-ScR recommendations and the protocol defined by the Joanna Briggs Institute. Search in 4 databases: Latin American and Caribbean Literature on Health Sciences (LILACS), National Library of Medicine (PUBMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Web of Science and considered studies from the last 5 years. Result: Final sample of 10 studies. Several difficulties were identified among the nurses in the spiritual care of palliative patients, namely: lack of training; lack of time; lack of recognition; lack of trust; avoidance; late referral; nurses' spirituality underdeveloped; different beliefs. Conclusion: We identified multiple difficulties experienced by nurses in spiritual care, either due to deficits in training, organizational deficits, or personal deficits.

Keywords: Palliative Care; End-of-Life Care; Nursing; Spirituality; Spiritual Care.

RESUMEN | Mapear la evidencia científica sobre las dificultades experimentadas por las enfermeras en la atención espiritual de pacientes en cuidados paliativos. Método: Scoping Review, basado en las recomendaciones PRISMA-ScR y en el protocolo definido por el Instituto Joanna Briggs. Búsqueda en 4 bases de datos: Latin American and Caribbean Literature on Health Sciences (LILACS), National Library of Medicine (PUBMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL) y Web of Science. Resultado: Muestra final de 10 estudios. Se identificaron varias dificultades entre las enfermeras en la atención espiritual de los pacientes paliativos, a saber: falta de formación; falta de tiempo; falta de reconocimiento; falta de confianza; evitación; derivación tardía; espiritualidad de las enfermeras poco desarrollada; creencias diferentes. Conclusión: Se identificaron múltiples dificultades experimentadas por las enfermeras en la atención espiritual, que pueden explicarse por déficits formativos, organizativos y personales.

Palabras claves: Cuidados paliativos; Cuidados al final de la vida; Enfermería; Espiritualidad; Cuidados espirituales.

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INTRODUCTION

The increase in the prevalence of chronic and degenerative diseases is closely related to the increase in average life expectancy that has been observed, which leads to the need to change the paradigm of care. It is essential that, in the case of a person with a serious illness with no prospect of a cure, the focus is no longer on treating and curing illnesses and becomes meeting the multidimensional needs of the person and their family members. It is in this context that palliative care (PC) emerges, based on an approach that aims to enhance the quality of life of people with an incurable and/or serious, progressive and advanced disease,

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as well as their families, as biopsychosocial and spiritual beings.¹

Spirituality can be defined as a person's ability to be aware of himself, to seek meaning for the events of his life and an existential purpose². It consists (on/) of the person's attempt to relate to the transcendent to find meaning, purpose and hope³.

Thus, when a person is faced with a diagnosis of a disease with no prospect of cure, spiritual suffering may be associated with loss of meaning, loss of meaning in life and loss of hope⁴. Several researches show that there is a strong connection between health and spirituality⁵, with the latter contributing to well-being and acting as a coping strategy, helping people to deal with stressors² making it beneficial to include spirituality in the practice of care⁶.

In fact, the spiritual dimension, being something intrinsic to the person, needs to be a central component in quality PC, becoming an integral part of the essence of the palliative approach⁷.

Even with the recognition of the importance of this care, spirituality continues to be the most neglected dimension in the last moments of people's lives and the most unknown in CP⁸, so intervention directed at the spiritual dimension during the process of caring for people with an incurable disease and/or severe, progressive and advanced is practically inexistent or even null⁹. In view of the above, we opted for the elaboration of a scoping review, with the objective of mapping the scientific evidence regarding the difficulties of nurses in providing spiritual care in PC.

METHOD

This is a scoping review type study. This methodology constitutes a secondary study, resulting from reviews of primary studies and has gained more and more importance, having become a reference, as the number of primary research studies has grown¹⁰.

To prepare the scoping review, we used the protocol defined by the Joanna Briggs Institute (JBI)¹⁰ and the PRISMA extension for scoping review¹¹.

For the research strategy and identification of studies, we resorted to the PCC-Population, Concept and Context strategy. The following were also defined as inclusion criteria: Participants – nurses; Concept – nurses' difficulties in providing spiritual care for people undergoing PC; Context – CP units (inpatient, in-hospital, community team).

On the other hand, studies that are not available in full text were defined as exclusion criteria.

The eligibility criteria obeyed the following parameters: Type of Study – considering primary studies (qualitative, quantitative and mixed); Language – considered publications available in Portuguese, Spanish and English; Publication date – considering studies from the last 5 years (2017-2022).

The database search took place between June 9, 2022 and June 25, 2022.

In a first phase, we carried out a random and exploratory search with terms related to spirituality in PC, in order to understand which descriptors were most used.

In a second phase, we define the terms of the Boolean phrases for carrying out the final search, identifying the respective descriptors through the terms Medical Subject Headings (MeSH): Spirituality; Spiritual Care; Palliative Care; Terminal Care; End of Life; Difficulties. In a third phase, the bibliographic references of all studies selected for full reading were analyzed, in order to identify additional studies.

This research was applied in four databases: Latin American and Caribbean Literature on Health Sciences (LILACS), National Library of Medicine (PubMed), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Web of Science, considering the following Boolean search phrase: Palliative Care OR End of Life OR Terminal

Care AND Difficulties AND Spirituality OR Spiritual Care.

The research, selection and reading of the studies were carried out by two reviewers independently.

Data were also independently extracted by two reviewers, using an instrument developed by the investigators for this purpose and aligned with the objective of the scoping review, consisting of the following items: study identification; study authors; year of study; country where it was developed; purpose of the study; type of study/design; sample/participants; data production instruments and/or techniques; main results; main conclusions.

The presentation of selected studies and results was carried out using tables, in order to summarize the information found.

Categorization was the form adopted for analyzing the results, and the categories that emerged were validated by all investigators.

RESULTS

In the research, the results were presented using tables, in order to systematize and make the analysis more perceptible. In a first phase, 3858 studies were identified for review through a search in electronic databases: LILACS, PUBMED, CINAHL e Web of Science. Also, electronically, 315 duplicate studies were identified and removed, leaving 3543 studies for analysis.

After screening the findings based on the title and abstract, we found that 52 studies met the defined inclusion criteria. We proceeded to analyze the bibliographic references of the 52 studies selected for full reading and 3 more studies were included in the research.

These 55 studies were analyzed in full and the inclusion and exclusion criteria were applied, with the support of completing a checklist constructed for this purpose. Studies that met these 3 criteria were eligible to be part of the

final selection and we were left with a final sample of 10 studies. Reading sheets of these 10 studies were carried out. The process of research and selection of studies for this scoping review is represented in the PRISMA flowchart (Figure 1).

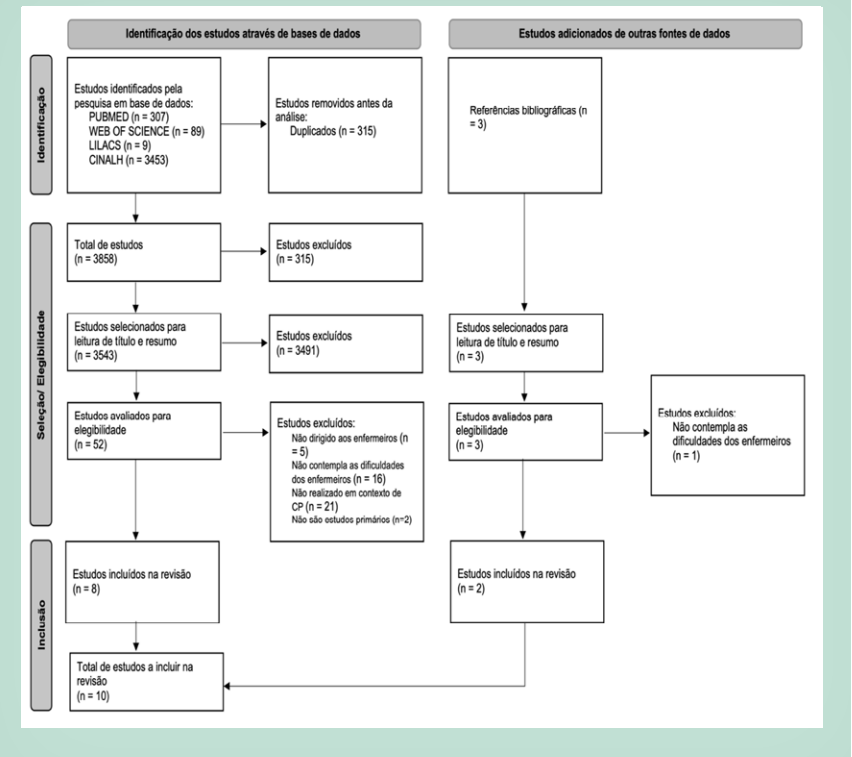
The 10 selected studies had dates between 2017 and 2022. We found that 1 study was published in 2017, 2 studies were published in 2019, 1 study was published in 2020, 5 studies were published in 2021 and 1 study was published in the year 2022. As for the type of study, they are mostly qualitative (8 studies) and 2 mixed.

With regard to nationality, we found that this is a subject studied in numerous countries, namely Denmark, Ireland, USA, Brazil, Switzerland, Spain, Germany and South Korea, which shows a transversal and international concern.

With regard to the context where the studies were carried out, it was found that most of them took place in a hospital context, with only 2 of them in a mixed context (hospital and community).

We present, in the following table,

Figure 1 - Flowchart of the study selection process for the Scoping Review adapted from PRISM²¹



Source: prepared by the authors, 2023

Tabela 1 – Apresentação dos estudos da scoping review

Nº	Study title	Author	Year	Country	Study Design	Participants/ Sample
E1	Four aspects of spiritual care: a phenomenological action research study on practicing and improving spiritual care at two Danish hospices ¹²	Viftrup et al.	2021	Dinamarca	Qualitative study (action-research); Interview focus group	-Nurses, doctors, physiotherapists, chaplains, cooks and auxiliary staff (9 focus group interviews with 5-8 participants in each group; 12 interviews with sick people)
E2	How specialist palliative care nurses identify patients with existential distress and manage their needs ¹³	Fay e Boyle	2019	Irlanda	Qualitative study; semi-structured interviews	Ten nurses (seven in community PC and three in hospital PC)
E3	Interprofessional Perspectives on Providing Spiritual Care for Patients with Lung Cancer in Outpatient Settings ¹⁴	Siler et al.	2019	EUA	Qualitative study; Telephone interviews and group sessions	19 health professionals with experience in oncology and PC (nursing, medicine, social worker and chaplaincy)
E4	Nurses' performance in palliative care: spiritual care in the light of Theory of Human Caring ¹⁵	Evangelista et al.	2021	Brasil	Qualitative, exploratory study; Semi-structured interview	10 nurses who worked in CP
E5	Nurses' response to spiritual needs of cancer patients ¹⁶	Zumstein-Shaha, Ferrell e Economou	2020	EUA e Suíça	Qualitative study; Qualitative Survey	62 nurses with experience in dealing with palliative patients

E6	Spirituality in Patients at the End of Life-Is It Necessary? A Qualitative Approach to the Protagonists ⁸	Navarro, Ortega e Navarro	2022	Espanha	Qualitative phenomenological study; semi-structured interviews	7 sick people and 10 professionals specializing in end-of-life processes (of which 7 were nurses)
E7	The Provision of Spiritual Care in Hospices: A Study in Four Hospices in North Rhine-Westphalia ¹⁷	Walker e Breitsamer	2017	Alemanha	Qualitative study; Semi structured interview	22 workers from the 4 hospices, of which 5 were nurses
E8	Hospice palliative care nurses' perceptions of spiritual care and their spiritual care competence: A mixed-methods study ¹⁸	Kang et al	2021	Coreia do Sul	Mixed method; Questionnaire + focus group interview	282 nurses in 40 PC institutions + focus group interviews with 6 PC specialists
E9	Nurses' training and teaching-learning strategies on the theme of spirituality ¹⁹	Oliveira, Oliveira e Ferreira	2021	Brasil	Qualitative method; Semi-structured interview	34 nurses from an oncology hospital
E10	A Survey of Hospice and Palliative Care Nurses' and Holistic Nurses' Perceptions of Spirituality and Spiritual Care ²⁰	Lukovsky et al.	2021	Nova Iorque	Mixed Method; Scale (SSCRS); Survey with open questions	Nurses from the Hospice Palliative Nurses Association and the American Holistic Nurses Association (n = 250).

Source: elaborated by the authors, 2023.

Table 2- Summary of the objectives and results of the scoping review studies

Nº	Goal	Results
E1	Explore how participants perceived, felt, lived, practiced and understood spiritual care in hospital centers and how spiritual care could be improved.	Unsatisfied spiritual needs due to lack of time in the nurse-patient interaction (even with a reference nurse); More confident and comfortable nurses in physical aspects; Wrong understanding of the spiritual needs of sick people and recognize that they have to evolve to that level.
E2	Explore how PC nurses identify sick people with existential angst and manage their needs.	Difficulty in establishing relationships with sick people in distress, reporting situations of avoidance and feelings of frustration when they felt they could not help; desire to distance themselves from sick people suffering from existential anguish as a method of self-protection; can be emotionally demanding; early identification of existential anguish by them could allow timely intervention.
E3	Explore the perspectives of health professionals with experience in PC and oncology on current challenges and facilitating factors in meeting spiritual needs.	Referral to social worker and chaplain; difficulties in approaching spirituality in his absence; approach to spirituality more difficult to approach than the physical dimension; they only question the existence of any religion; They are not comfortable with spiritual matters; lack of training.
E4	To analyze the role of nurses in assisting sick people in PC, with emphasis on the spiritual dimension, in the light of the Theory of Human Care.	Personal issues, professional training, service structure, work routine, ratios and lack of time do not allow approaching spirituality; spiritual dimension is something delicate, difficult, complicated, limited to physical care and active listening.
E5	Explore nurses' reporting of the spiritual needs of sick people.	Difficult to talk about religious and spiritual issues with sick people because they are not held regularly; is not questioned; religion and spirituality were not considered important issues within their institutions; lack of confidence leads to hesitation; "private affairs"; difficulties in identifying the most competent professional; shortcomings of the respective organization or institution; feelings of frustration and impotence when sick people refused care; trained nurses did so more regularly; it is important that they have time.
E6	Identifying the spiritual needs of sick people at the end of life and how nursing professionals can work to provide effective follow-up.	Need for training and tools; training as a solution to integrate the spiritual component into care; it is not answered, not even in the CP; it is not integrated as part of work, because they have to respond to other interventions that are expected from the nursing class.
E7	Explore how spiritual care is provided in hospices and what is meant by spirituality.	Highly undefined concept of spirituality; limited knowledge about approaching spirituality and different religions; questioned only religion on admission; spiritual diversity is a challenge; hesitant in dealing with people whose religious affiliations differ; spirituality does not have the value that one might expect; time is spent on more practical things; non-approach could be related to short periods of hospitalization until death; training as an essential but not sufficient condition.
E8	Understand the perceptions of hospital PC nurses in relation to spiritual care and their competence to provide spiritual care.	Nurses with a master's degree were more competent; difficulty meeting spiritual needs; limited and insufficient preparation; abstract concept and difficult to approach; busy schedule; difficult to practice spiritual care during working hours; nurses are not capable of reflecting sufficiently on their spirituality.

E9	To investigate whether and how the theme of spirituality was approached in the training of nurses who work in PC.	Training needs; nurses value the theme in professional training/qualification and consider its inclusion as relevant and experience in PC important to consider this dimension; absence or insufficient approach to the subject in academic and professional training; 97.1% without any proximity to the subject; continuous training as the only possibility to prepare nurses to take care of the spiritual dimension of sick people.
E10	Evaluate the perceptions of hospital, palliative and holistic nurses about spirituality and spiritual care.	- During the degree, 42.5% had no contact with the subject; 22% indicated that the primary provider of spiritual care should be a chaplain; 60.6% considered that they should be provided by all parties involved; all indicated having encountered a sick person with spiritual needs; 53% claimed to have become aware of the sick person's spiritual needs; 64.9% answered that they are able to satisfy the sick person's spiritual needs; more than 80% indicated that they address the spirituality of the sick person in their daily practice; 91.7% considered that they received sufficient training.

Source: elaborated by the authors, 2023

the main characteristics of each study present in the final sample (Table 1).

We also present the objectives and results of the studies that made up the final sample, with reference to the objective of the scoping review (Table 2).

In order to synthesize the results and through the categorization, we present a table that shows the synthesis regarding the difficulties of nurses in the spiritual care of the person in PC (Table 3).

Thus, after this analysis of the results, 8 categories emerged from referring to the nurses' difficulties in the spiritual care of the person in PC: lack of time; nurses' lack of confidence; nurses' avoidance of providing spiritual care; lack of training; poorly developed nurses' spirituality; late referral to PC; organization's lack of recognition of the importance of spiritual care; and different beliefs between nurses and sick people. We found that, of the defined categories, the lack of training is the most mentioned, having been identified in 90% of the studies, followed by the lack of time identified in 60% and the organization's lack of recognition of the importance of spiritual care in 50%. The remaining categories are situated between 30% and 10% of the studies.

DISCUSSION

After mapping the scientific evidence regarding the difficulties of nurses in providing spiritual care in PC, an analytical, critical and reflective discussion of the findings is required.

Spirituality constitutes an intrinsic dimension of the person and, according

Tabela 3 - Dificuldades dos enfermeiros no cuidar espiritual da pessoa em CP

Dificuldades sentidas	Estudos que fazem referência	Nº referências (n)	FR (%)
Falta de tempo	E1; E4; E5; E6; E7; E8	6	60%
Falta de confiança dos enfermeiros	E1; E3; E5	3	30%
Evitamento pelo enfermeiro em prestar cuidados espirituais	E2; E5	2	20%
Falta de formação	E1; E3; E4; E5; E6; E7; E8; E9; E10	9	90%
Espiritualidade dos enfermeiros pouco desenvolvida	E8	1	10%
Referenciação tardia para os CP	E1; E7	2	20%
Falta de reconhecimento da organização da importância dos cuidados espirituais	E3; E4; E5; E6; E7	5	50%
Crenças diferentes entre enfermeiros e pessoa doente	E7	1	10%

to Evangelista et al.²¹, a crucial factor in providing nursing care to people with incurable and/or severe, progressive and advanced disease. Effectively, spirituality must be a substantial component of care in PC.

The analysis of scientific production showed that the importance of spiritual care in PC is recognized by nurses in most studies^{8,14-17,19-20} and scientific evidence demonstrates this recognition as significant for the care process^{6,18, 21-26}. However, even with the recognition of its importance, there are some barriers to the inclusion of spiritual care by nurses. Among the various difficulties of nurses in providing spiritual care in PC that emerged from the analysis of the studies

in this review, we can highlight: Lack of time (60%); Nurses' lack of confidence (30%); Avoidance by the professional to provide spiritual care (20%); Lack of training (90%); Nurses' spirituality poorly developed (10%); Late referral to PC (20%); Lack of recognition of the importance of spirituality by the organization (50%); Different beliefs between nurses and sick person (10%).

On the one hand, if there is recognition by nurses of the importance of spiritual care, on the other hand, there is also an ambiguity in understanding the functions of these health professionals in this regard and what goes beyond their functions²⁷. There is a tendency to delegate spiritual care to the

religious leader^{14,20}, which is corroborated by other studies²⁸⁻³⁰. Some situations are highlighted in which nurses ask other professionals to collaborate because they do not have the ability to deal with spiritual matters¹⁴⁻¹⁵ as a social worker¹⁴ or, even, there is difficulty in identifying the most competent professional to answer these questions¹⁶. In the study by Lukovsky et. al²⁰, 22% of the nurses mentioned that the chaplain would be the main provider of spiritual care, while the rest considered that it should be provided by the entire team. This last result is in line with the results of a study, which was carried out with the aim of knowing the perception of health professionals in relation to spiritual care, having found that they consider it necessary to involve the entire team to detect spiritual needs and /or religious²⁵. In fact, the collaboration between nurses and chaplains is essential to provide spiritual support in health institutions³¹ and it is difficult to provide spiritual support in the absence of a chaplain within the teams³². Undoubtedly, the spiritual and religious support service constitutes a link in the multidisciplinary team that ensures comprehensive care³³ for people with incurable and/or serious, progressive and advanced illnesses and improves the quality of care³³.

The difficulty related to lack of training was the most pronounced in the results of this scoping review^{8,14-20}. Spiritual care was described as something difficult^{14-16,18}. In fact, there is a vast literature that refers us to the lack of training as a decisive and impeding barrier for nurses to provide spiritual care^{18,20-21,26,34-37}.

In contrast, in the study by Lukovsky et. al²⁰, the vast majority of respondents (91.6%) considered that nurses received sufficient instruction and training on issues related to spiritual care and 64.9% responded that they are capable of meeting the spiritual needs of the sick person. These results demonstrate that nur-

ses who are trained in spiritual matters are more comfortable within the spiritual realm. Zumstein-Shaha, Ferrell and Economou¹⁶ also found that nurses who were trained in spiritual care performed it more regularly and Kang et. al¹⁸ found that nurses with a master's degree were more competent in spiritual care. Through these results we can attest that the lack of training is the main cause of difficulties in the integration of spiritual care as a response to the needs of the person in a palliative situation. However, these barriers can be overcome by health professionals as they focus on training^{21,34-36}. Despite the lack of training being a reality evidenced in this scoping review^{8,14-20}, the willingness of nurses to invest in training in spirituality is also reported⁸. In the same sense, the study by Farahani et. al³⁷ and Silvermann et. al³⁸ demonstrate similar situations. Farahani et. al³⁷ reports that 75% of nurses were willing to participate in training courses on spiritual care; and the one by Silbermann et. al³⁸ that 68% of the participants expressed interest in evolving from the training point of view regarding this theme. Thus, it is urgent to integrate spirituality into nursing curricula^{8,14-20,39}, which demonstrates the importance and recognition of spirituality as a human dimension that should not be neglected in nursing care for people in palliative care.

In the study by Walker and Breitsameter¹⁷, the difficulty in caring for people with incurable and/or severe, progressive and advanced disease with different religions from the nurse's religion is evident, whereby cultural diversity can be seen as a limitation for the provision of spiritual care⁴⁰. In this way, training on different cultures and religions enhances intervention in the dimension of spirituality⁴¹. On the other hand, the confusion of concepts between religion and spirituality can also be at the core of this limitation^{21,42}, so the spiritual care of the person with an incurable and/or serious, progres-

sive and advanced disease can be influenced by the nurse's own spirituality and by the training on religious, cultural and spiritual differences⁴³. Once again, it is concluded that training is a cornerstone in the training of nurses for spiritual care.

According to our results, nurses state that it is difficult for them to provide spiritual care to people with incurable and/or serious, progressive and advanced disease, as they themselves are not capable of sufficiently reflecting on their spirituality¹⁸. The results obtained are in line with several studies⁴⁴, which revealed that the more advanced the spiritual health of nurses, the better their attitude towards spiritual care. Thus, the willingness of nurses to provide spiritual care is influenced by their spiritual self-knowledge and those who are concerned with their spiritual aspects provide better spiritual care⁴⁵. It seems that a greater awareness of the spiritual "I" can be a fundamental step for nurses to become interested in spiritual issues and have more competence to intervene in the dimension of spirituality.

Another difficulty for spiritual care in PC is related to the lack of time, mentioned in several studies of this scoping review^{8,12,15-18}. In a study by Farahani et. al³⁷ carried out in Iran with the objective of examining the barriers to the implementation of spiritual care, the impeding factor with the highest score was lack of time. In that same study, the lack of time is justified by the shortage of nurses in Iran, affecting the quality of care, which is why they are limited to essential care³⁷. In the results of the scoping review studies, similar situations were found, in which spiritual practices were not encouraged by high nurse-patient ratios^{15,18}, due to lack of time to talk to the sick person about these issues¹⁶, because they had to respond to other interventions that are expected from the nursing class⁸ and because time is spent on more practical aspects¹⁷. Other authors corroborate

that the lack of time constitutes a difficulty in spiritual care^{34-35,46-47}.

Also, the lack of confidence in addressing the dimension of spirituality on the part of nurses emerged from the analysis of selected studies^{12,14,16}. In the study by Viftrup et. al¹² and by Siler et. al¹⁴, nurses felt more comfortable in taking care of the physical aspects, as well as in the investigation by Zumstein-Shaha, Ferrell and Economou¹⁶ which found a lack of confidence in taking care of the spiritual aspects. Terms such as "hesitations" and "insecurities" in approaching spiritual issues¹² also emerged, terms that denounce discomfort and uncomfortable in carrying out this intervention. It is noticed that this lack of confidence of nurses in spiritual care is related to the lack of training, since the aforementioned studies that address this difficulty^{12,14,16} also have underlying and as results, the need to evolve from the educational perspective. Nurses' lack of confidence in addressing these issues was also detected in a study by Christensen and Turner²⁸ and was due to these professionals considering that the spiritual sphere would be a private matter, which is also addressed by other studies^{16,37,40,47}.

In the same way that lack of confidence interferes with the provision of spiritual care, the nurse's own belief system can also have implications at this level, which can lead to situations of avoidance on the part of the professional^{13,16}. Nurses' attitudes towards the end of life may also be related to feelings of sadness, frustration and avoidance, as reported by participants in the study by Fay and Oboyle¹³. In this same study¹³, two nurses admitted the desire to stay away from sick people as a method of self-protection. This avoidance on the part of professionals to provide spiritual care to the sick person at the end of life is corroborated by other authors⁴⁸⁻⁴⁹, being situations that generate feelings of impotence and failure due to the inevitability of death and distancing⁵⁰.

The study by Kudubes et. al³⁹, demonstrated a negative correlation between escape behavior and nurses' perceptions of spiritual care. Also the studies by Zyga et. al⁵¹ and Cevik and Kav⁵² arrived at the same results. Thus, in order to have positive changes in the attitude of nurses in relation to death and the perception of spiritual care, the existence of training programs becomes important³⁹.

Late referral to PC as a limitation for spiritual care was also identified by studies by Viftrup et. al¹² and from Walker and Breitsameter¹⁷. It was found, in these same studies^{12,17}, that sick people died before the nurses had time to get to know them sufficiently to attend to their spiritual needs. The establishment of a therapeutic and empathetic relationship facilitates the understanding of these same spiritual needs⁵³.

Finally, organizational and institutional gaps were identified as obstacles to spiritual care in PC. In the study by Zumstein-Shaha, Ferrell and Economou²⁹ reports were identified that spirituality is never approached and that neither religion nor spirituality were considered important issues within the institutions, not being integrated into the work "routines"¹⁹. In the study by Walker and Breitsameter³⁰, when asked how much importance is attributed to spirituality in the daily practice of hospital care, nurses reported that they do not have the value that one might expect and that time is spent intervening in aspects related to the physical dimension³⁰. In this way, the lack of institutional sensitivity ends up interfering with the provision of spiritual care³⁴, so the PC must be configured in an approach regulated by humanization and solidarity on the part of those who provide them⁹².

In the present scoping review, we identified some limitations, such as the inclusion only of studies published in Portuguese, Spanish and English. Thus, studies published in other languages

could also have provided important data. Also, if we had access to other studies in addition to full access, we could have encountered other difficulties on the part of nurses in addressing spirituality in the context of PC.

CONCLUSION

Caring for people with an incurable and/or serious, progressive and advanced disease creates a highly complex environment in health services and requires professionals with competence to deal with the multidimensional needs of sick people and their families, including spiritual needs. The main reasons why nursing professionals do not respond to the spiritual needs of people in palliative care are essentially due to lack of training. Added to this is the lack of confidence, the late referral to PC services, the nurses' avoidance of providing spiritual care, the lack of time, the spirituality of nurses underdeveloped, the organization's lack of recognition of the importance of spiritual care and different beliefs between nurses and sick people.

In summary, there are several difficulties experienced by nurses in spiritual care in PC, which gravitate around 3 axes: deficits in training, organizational deficits and personal deficits in the way of dealing with this dimension of care.

The importance of sensitizing health professionals, in general and nurses in particular, to the relevance of spiritual care in PC is increasingly evident.

In this sense, it is essential that there is a more consolidated commitment to the development of spiritual care skills on the part of both higher education institutions and health institutions, integrating this dimension of care into their study plans and practice, respectively, thus, enabling more complete, ethical and humane care for people in a palliative situation. 🌿

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