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Research Article

Spiritual needs during COVID 19 pandemic in the perceptions of Spanish emergency critical care health professionals

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ABSTRACT

Objectives: To investigate the perceptions and attitudes of health professionals working in emergency services and critical care units in Spain about spiritual care provided during the COVID-19 pandemic.
Methods: A qualitative investigation was carried out using in-depth interviews.
Setting: Emergency and emergency and ICU health professionals from different regions of Spain.
Findings: The sample consisted of 47 nursing and one nursing assistant. The qualitative analysis yielded four main themes that reflect the following categories: "the experience with spirituality in clinical practice"; "resources and barriers to provide spiritual care"; "the COVID pandemic and spiritual care" and "training in spiritual care". In addition, two subdeliveries were also obtained: "ethical dilemma" and "rituals of death".
Conclusions: The majority of emergency and critical care nurses believe spiritual care is important to their clinical practice, but there are still several barriers to address patients' spiritual needs. During the COVID-19 pandemic in Spain, professionals felt that spiritual beliefs have emerged as important needs of patients and the restrictions imposed by the pandemic made health professionals more exposed to ethical dilemmas and end-of-life religious issues. The general impression of health professionals is that more training and resources are needed on this topic.
Implications for clinical practice: Health professionals in emergency intensive care must provide nursing care that meets the spiritual needs of their patients to improve care in crisis situations such as the one suffered by the COVID-19 pandemic. For this, emergency services professionals must work and participate in the development of measures to overcome certain barriers present in emergency services, such as lack of time, lack of training and misconceptions that make it difficult to approach emergency services these needs.

Introduction

As the definition of health and disease has evolved into a complex integrative and multidimensional construct; other overlooked dimensions, such as spiritual beliefs, have been incorporated into healthcare (Guirao Goris, 2013). Although there are different definitions, for the present study, spirituality will be considered "the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski & Larson, 1998).

In recent decades, spirituality research has been increasingly consolidating in the scientific community (Lucchetti & Lucchetti, 2014) spiritual beliefs have been recognised as a powerful coping mechanism

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for dealing with traumatic events (Koenig, 2012), allowing a more optimistic perspective and fostering faith and hope (Ortega Jiménez et al., 2016).

Despite this promising evidence, previous studies have shown that spirituality is not well valued in nursing education and poorly addressed in clinical practice (Lewinson et al., 2015). Nurses report that they feel a lack of knowledge, understanding, and skills in spiritual care and that addressing spirituality demands more knowledge and skills than they have (de Diego Cordero et al., 2019). Among the most common barriers reported by nurses, workload, lack of training, fear of imposing own beliefs, lack of time, lack of motivation and patient privacy were mentioned (Alch et al., 2021; Riahi et al., 2018; Veloza-Gómez et al., 2017).

Spiritual care is particularly important for critical care and emergency health providers, given that they work at stressful environments where patients are in critical and life-threatening conditions (Riahi et al., 2018). Previous research has supported that such patients consider important that health professionals address their spiritual needs in this situation (Santana Biondo et al., 2017). However, spiritual care does not seem to be perceived as a priority in emergency services, so it is often neglected and not present in acute care nursing, even though it can support patients and families to face adversity and existential issues such as death (Santana Biondo et al., 2017; Swinton et al., 2017). Likewise, spirituality seems to be important to health providers. Workload, ethical dilemmas, and stress also put the emotional well-being of healthcare professionals in critical care services, experiencing problems of anxiety and depression (Romero-García et al., 2022) and spiritual beliefs could be important coping mechanisms as well.

The pivotal role of spirituality in healthcare has been supported in the recent moment during the COVID-19 pandemic (de Diego-Cordero et al., 2022). Since the beginning of the pandemic, there have been more than 300,000,000 cases and 5,500,000 deaths from coronavirus (World Health Organization, 2021). This crisis has been a challenge for health systems around the world, testing contingency and public health plans (Sebastián Rocchetti et al., 2020). During the initial response to the surge of the pandemic, the spiritual and psychological needs of patients and their families lost priority and many critically ill COVID-19 patients died in isolation without appropriate support (Galbadage et al., 2020). This situation has meant an urgent need to address spiritual needs of these patients given the degree of isolation, loneliness, and vulnerability caused by this pandemic (Ferrell et al., 2020).

In Spain, the state of alarm was declared on March 14th 2020, which lasted until June 21st 2020 and led to home confinement, the suspension of educational, commercial, recreational and leisure activities, among others, limiting the exit of individuals only for the purchase of food and medicine, health care or going to work (Real Decreto 463, 2020). The number of deaths in Spain was one of the highest in the World and the work overload of emergency personnel and the lack of hospital resources were definitely a problem (Dosil Santamaría et al., 2021).

In these difficult scenario, the use of spirituality and religiosity during isolation has been identified as a protective factor against anxiety, depression and suicide (Fountoulakis et al., 2021) and has been associated with better health outcomes (higher levels of hope and lower levels of fear, worry and sadness) and less suffering (Lucchetti et al., 2021).

Within hospitals, where feelings of vulnerability, stress, or helplessness are more frequent, spiritual care has emerged as an important healthcare tool (Badanta et al., 2022). Nevertheless, the lack of chaplains and certified religious leaders due to the risk of contagion, as well as, the unfamiliarity and lack of training of health providers with spiritual care, made several patients not having their spiritual needs met. (Ferrell et al., 2020; Santana Biondo et al., 2017).

A previous study aimed to analyse empirical evidence on the influence of Spirituality on critical care nursing (Ho et al., 2018). Furthermore, another article aimed to investigate the perceptions and attitudes of nurses working in intensive care units (ICU) in Spain about the spiritual care provided to patients and their families during the COVID-19 pandemic (de Diego-cordero et al., 2021).

In this context, the present study aims to investigate the perceptions and attitudes of health professionals working in emergency services in Spain about spiritual care provided during the COVID 19 pandemic.

Methods

Study design

A qualitative, exploratory, and observational study was conducted using a phenomenological approach. This approach aims to describe the meaning of an experience by identifying essential subordinate and major themes (Moser & Korstjens, 2018).

Data collection consisted of in-depth interviews conducted by qualified investigators in two moments, from January to June 2020 (first wave of COVID-19 pandemic in Spain) and from February to May 2021 (third wave), totaling 10 months of data collection.

Setting, sample, and eligibility criteria

Phenomenology uses criterion sampling, being the most prominent criterion the participant's experience with the phenomenon under study (Moser & Korstjens, 2018). Therefore, participants were included provided they were nurses working in intensive care units (ICUs) or emergency services from both public or private health institutions in Spain and treating critically ill patients with COVID-19. While the ICU nurses worked in hospitals, emergency care was provided in hospitals, primary care, and outpatient emergency units. Religious personnel from hospital centers, health professionals who were working outside ICUs or emergency services, as well as those not caring for patients (i.e., academic or management level) were excluded.

Procedures

A WhatsApp message that included a poster describing the study was widely distributed using professional and personal contacts (i.e., graduate students, registered nurses, and critical care and emergency services managers). Since this is a specific sample (emergency critical care personnel), very busy in the context of COVID-19 and usually difficult to be reached and to be willing to participate in interview studies, we have opted to add a snowball sampling procedure as well, in which participants interviewed by researchers were asked to suggest names of colleagues to take part in the study (Higginbottom, 2004). Interested participants directly contacted the researchers and eligibility criteria were applied. The eligible participants were invited by the main researcher, who is a nurse and anthropologist with expertise in spiritual care and has published several articles in the field of "Spirituality and Health".

Since Spain was facing the implementation of a 'state of emergency' during the first wave of COVID-19 and there were restrictions for the free movement of people between Spanish cities in the third wave, no face-to-face meetings with health professionals were allowed. For this reason, interviews occurred individually at a time convenient to the participants (that is, respecting their preferences), using electronic devices. In this way, recordings of telephone calls and video calls were made using web meetings tools. The interviews were carried out by two researchers in the Spanish language and lasted approximately 50 to 60 min. Data collection continued until data saturation was reached. It was when no new analytical information was identified, and the study provided maximum information on the phenomenon (Urra et al., 2013).

Instrument

Since we opted to a phenomenological approach, semi-structured questions were used along with exploratory questions to clarify the

lived experience of the participants. An interview script was developed, and the questions script was designed to encourage participants to tell their personal experiences, including feelings and emotions, and often focus on a particular experience or specific events (Moser & Korstjens, 2018).

The content of this interview script was developed using the Delphi method approach. The Delphi technique is an exercise in group communication that brings together and synthesises the knowledge of a group of geographically scattered participants (Boulkedid et al., 2011). In our case, we opted to an e-delphi approach, where experts were invited and fill in the forms online. A consensus ~~of~~ was considered for each question and a total of 15 experts in spiritual health and/or critical care were invited and agreed to participate. The characteristics of the expert panel are shown in the Table 1. In order to achieve a consensus for all items of the delphi, two rounds of assessments were needed. Finally, the interview script was adapted according to the experts analysis (Table 2).

Table 1
Characteristics of Experts for Delphi Panel.

Code	Age	Gender	Residence	Highest academic level	Occupation
Expert 1 – 1° wave	40	Woman	Murcia	PhD	Medical anthropologist
Expert 2 – 1° wave	59	Woman	Seville	PhD	University professor / ICU nurse
Expert 3 – 1° wave	63	Woman	Seville	PhD	University professor / palliative care specialist
Expert 4 – 1° wave	57	Woman	Seville	MRcN	University professor / midwife / Expert in community nursing
Expert 5 – 1° wave	43	Woman	Seville	PhD	University professor in religious center
Expert 6 – 1° wave	42	Woman	Seville	PhD	University professor in religious center
Expert 7 – 1° wave	33	Woman	Seville	PhD	University professor in religious center
Expert 8 – 1° wave	59	Man	Granada	PhD	Psychologist / EASP
Expert 9 – 1° wave	33	Woman	Seville	MRcN	Research nurse
Expert 10 – 1° wave	47	Man	Brazil	PhD	Doctor
Expert 1 – 3° wave	33	Woman	Seville	PhD	Emergency nurse
Expert 2 – 3° wave	48	Man	Seville	Master	Emergency nurse / University professor
Expert 3 – 3° wave	60	Man	Seville	Doctor	Emergency nurse / University professor
Expert 4 – 3° wave	24	Woman	Seville	PhD	Emergency nurse
Expert 5 – 3° wave	45	Hombre	Seville	PhD	Emergency nurse / University professor

Table 2
Interview Guide.

1. Have you ever heard the term spiritual health? What do you mean by it?
2. Do you think that S / R influences in any way the health of patients, their coping with the disease? If so, how do you think it influence? Do you have any experiences or know some examples?
3. In your opinion, does the spirituality/religiosity of health professionals interfere with the professional-patient relationship? How does it influence?
4. Do you feel like discussing faith/spirituality with patients?
5. Have you ever asked your patients about religion/spirituality? * Yes (If the answer is "Yes": How often do you usually do it? When or in what situations do you usually address this question?) Have your patients ever shown any religious or spiritual aspect that characterized them?
6. How do you think you can provide spiritual care in your daily activity?
7. To what extent, from 1 to 10, with 1 not being prepared at all and 10 being totally prepared, do you consider yourself prepared to address religious/spiritual issues with your patients? Why?
8. Do you feel difficulties or barriers that discourage you from discussing religion/spirituality with your patients? Which?
9. What is the role of your spiritual or religious belief at the time in dealing with this situation?
10. Have you seen aspects of spirituality/religiosity emerge in you, your colleagues, patients or family members to cope with the COVID 19 situation?
11. How do you perceive that the beliefs of the individual infected with COVID 19 influence their evolution of the disease?
12. Have you ever experienced a critical situation of a patient who, due to spiritual/religious convictions, wants or rejects some type of care or treatment for COVID 19 that confronts or conflicts with their beliefs (ethical dilemmas)? g How would you deal with it or what would be your position if it happened?
13. What part of the restrictions during the pandemic (due to covid-19) do you think may affect or have affected the mood or spirit of the patient or their family?
14. Regarding the restriction of visitors or companions at this time, how do you think it affects the patient or family?
15. Have you experienced the situation of a death from COVID 19? How have you and your colleagues experienced it? Have any spiritual or religious elements been present at the death of a patient?
16. How do you think spiritual care could be improved? Are there any resources or help that might be helpful?
17. Do you think that the health system has offered adequate, equitable and ethical care to all people during the pandemic? In what cases? Have you experienced it in your work?
18. What is dignified and ethical care for your patients for you? Characteristics or implications
19. Are you foreseen or have you experienced insufficient resources for all patients and the prioritization of some patients over others?
20. Do you know of any end-of-life support protocol for people affected by COVID-19 and their families? Have you experienced such a situation? What do you think about it?
21. Have effective means been used in your unit to transmit information to family members or to communicate patients with their families? If so, what resources have been used? (calls, video calls…); What effect does it have on patients?
22. Has the implementation of psychological services in general, for patients, relatives or professionals been considered in your service/unit? What do you think about it? Who do you think would benefit the most?

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23. Do you consider it useful that these aspects and spiritual/religious care have more value within university education? Where: in undergraduate studies? In specific subjects? crosswise? in postgraduate studies: master or expert? Do you know something?
24. What level of importance could this training have for your work in the area of urgencies / emergencies? why?

Data analysis

The data were analysed using a phenomenological approach, which followed the Amadeo Giorgi theory (Giorgi, 1997). Phenomenological analysis implies capturing and describing the "life world" of the study participant, and it is important for the researcher to avoid interpretations of the narrated experiences of the study participants and to present the life world as it appears to the respondent (Nyström & Dahlberg, 2001).

Thematic analysis, as described by (Braun et al., 2019) was also used. Qualitative analysis was carried out using the following steps: (1) familiarisation with the data; (2) generation of categories; (3–5) search, review, and definition of themes; and (6) final report, which was

prepared with the statements of the informants, indicated by *participant number, gender, age, place of work, wave 1–3*, and transcription, literal reading and theoretical manual categorisation were performed. A Spanish-English translation of the manuscript was carried by a translation company, and for the quotations, an English-Spanish back-translation was performed by a Spanish native (n = 1).

Finally, the analysis and treatment of MAXQDA 12 qualitative data was used. MAXQDA is a software program designed for the use in qualitative, quantitative, and mixed methods research.

Trustworthy

This research followed The *Consolidated Criteria for Reporting Qualitative Studies* (COREQ) (Tong et al., 2007). The methods used for guaranteeing quality were data triangulation, including participants with different sociodemographic characteristics, and the triangulation of data analysis via different researchers *(See the Supplementary Material Table S1)*.

Ethical considerations

The study received approval from Andalusian Ethics and Research Committee (internal code: 1996-N-20). Participants were invited by the principal investigator to participate voluntarily, so they were incorporated into the study after accepting and signing the informed consent sent by email.

Findings

Description of the sample

The sample consisted of 48 professionals who work in Spanish ICU and emergency services, 70.8 % women with a mean age of 28.9 years (ranging from 22 to 52 years). Most of the participants were nurses (97,9%) and worked in emergency departments (60.4 %), from public health institutions (75 %) and lived in Seville (35.4 %), Cataluña (22.9 %) and Málaga (22.9 %). Regarding their spiritual and religious beliefs, 41.7 % of the sample defined themselves as spiritual and religious beings and 43.8 % were Catholics. A total of 25 % of participants had no religious affiliation and did not believe in God. The complete characteristics of the sample are shown in Table 3.

Table 3
Characteristics of the sample.

Variable	Participants (n = 48)	
	Absolute frequency	Relative frequency
Sex		
Female	34	70,8%
Male	14	29,2%
Mean age	28,9 years old	
Place		
Málaga	11	22,9%
Seville	17	35,4%
Barcelona	11	22,9%
Madrid	3	6,3%
Huelva	2	4,2%
Jaen	2	4,2%
Granada	1	2,1%
Cáceres (Jaraiz de la Vera)	1	2,1%
Beliefs		
Yes religious, Yes spiritual	20	41,7%
Yes religious, No spiritual	4	8,3%
No religious, Yes spiritual	8	16,7%
No religious, No spiritual	12	25,0%
I couldn't answer	4	8,3%
Religious orientation		
None, but I believe in God	7	14,6%
None and I don't believe in God	18	37,5%
Catholic	21	43,8%
Buddhist	1	2,1%
I believe in God and energy	1	2,1%
Work unit		
Emergency room	29	60,4%
Ambulatory care	4	8,3%
Ambulance	6	12,5%
Intensive care unit	12	25%
Family and community nursing home	1	2,1%
Others	2	4,2%
Financing the job you hold		
Public	36	75,0%
Public and private	8	16,7%
Concerted/Subcontracted	3	6,3%
Private	1	2,1%

The qualitative analysis yielded four main themes that reflect the following categories: "*the experience with spirituality in clinical practice*"; "*resources and barriers to provide spiritual care*"; "*the COVID pandemic* and *spiritual care*" and "*training in spiritual care*". In addition, two sub-deliveries were also obtained: "*ethical dilemma*" and "*rituals of death*".

These themes and sub-deliveries are described below.

Theme 1: The experience with spirituality in clinical practice

First, we wanted to know the previous perceptions that the participants had about spirituality. A total of 39.6 % of health professionals said they had never heard the term 'spiritual health', although they consider spirituality as something intangible that can improve hope and well-being, providing comfort and overcoming adverse situations.

> Participant 27, female, 23 years old, emergency care, 3ª wave: "*It makes you feel good about yourself* [spirituality]*, allowing you to have psychological and psychic health.*"

> Participant 3, female, 52 years old, ICU, 1ª wave: "*Truly I dońt know exactly what it refers to, I have never heard it, but I imagine that it is the need that certain people have to feel wrapped up or think of something that gives them that comfort or always have something there that they can hold on to, to which they can pray.*"

Second, the influence of religiosity/spirituality on the health of patients or to cope with the disease was explored. On this, there was agreement, 95,8% of the participants believed that there was such an influence.

A common conclusion that was repeated among the participants was that S/R helped patients and their relatives to better cope with adverse situations such as suffering from a disease, life-threatening illnesses, bereavement, and the death of a relative. According to the participants, spirituality serves as support and, in their view, patients who did not have these beliefs used to have a worse outcome.

> Participant 47, female, 28 years old, ICU and ambulance, 3ª wave: "*Having faith in something gives you a "light at the end of the tunnel" to try to evolve favorably in the disease.*"

> Participant 15, female, 26 years old, emergency care, 1ª wave: "*In matters such as grief, I think it is more bearable in religious people because they are really convinced of a spiritual afterlife.*"

After that, we wanted to know how they perceived that S / R influenced patient care. A common idea was that if the religious and/or spiritual beliefs of healthcare professionals coincided with those of patients, this could reinforce the relationship that was created between them, since the healthcare professional could empathize more with the patient and better cover their needs and could even improve the care and treatment they provided to their patients. Similarly, participants were observed to consider that they could have a negative relationship if beliefs did not coincide between the patient and the health professional.

> Participant 32, female 28 years old, emergency care, 3ª wave: "*I think the more spiritual a professional or a person is, the more compassion, connection, and spiritual and emotional closeness he can have with someone else and I also think more healing ability in terms of helping the other person and feeling good about oneself.*"

Participant 6, female, 22 years old, emergency care, 1° wave: "*I think it may interfere if it does not match the patient's beliefs, that is, for a healthcare system with religious beliefs it may be difficult to understand a patient with different beliefs and vice versa."*

Theme 2: Resources and barriers to provide spiritual care

Concerning the provision of spiritual care, 56.3 % of the participants reported that they did not address the spiritual needs of their patients, explaining that the workload, the professional neutrality, their own beliefs, the length of the patient's admission or that this is out of the scope of their job as potential barriers.

Participant 4, male, 31 years old, ICU, 1° wave: "*I believe that by not considering myself a spiritual person of faith I have never noticed that need in my patients, possibly wrongly on my part."*

Participant 29, male, 22 years old, emergency care, 3° wave: "*It is a topic that I don't like to deal with patients because every-one is free to think what they want."*

Regarding available resources, most of the participants reported not having had access to spiritual or religious resources. Common ideas that emerged as necessary were the establishment of times and spaces and the incorporation of personnel specialised in spirituality. Similarly, participants agreed that they addressed this issue when patients suggested it or in situations of a poor prognosis. Despite this, only eight of the participants said they had referred their patients to chaplains or religious leaders.

Participant 43, female 50 years old, emergency care, 3° wave: "*One thing, for example, that I have demanded a lot is that if the person is sick, we can offer him to come to the priest to be there with him."*

Participant 7, female, 22 years old, emergency care, 1° wave: "*In hospitals include more people who attend to the different religions that exist. In most hospitals there are only priests, but no imams for the Islamic religion, neither for the Jewish or Buddhist religion."*

We also tried to identify the barriers that health professionals found with respect to spiritual care and those highlighted were lack of training and ignorance about spirituality and/or religion, not feeling spiritual or religious, lack of time, and fear of discomfort or rejection.

Participant 18, female, 25 years old, emergency care, 1° wave: *"These aspects (spirituality/religiosity) are not usually shared with you."*

Participant 38, female, 25 years old, emergency care and ambulance, 3° wave: *"I believe that ignorance is the main reason why maybe I don't have that kind of conversation, because I don't know how to approach it."*

It was also seen that lack of training and knowledge made health professionals feel insecure about spirituality and, for this reason, doctors did not open the door to patients to talk about it. Other barriers that were described by the participants were lack of time, perspective and resources, workload, lack of privacy, and interruptions.

Participant 9, female, 23 years old, ICU, 1° wave: *"Is not something recognised. You cannot talk to your partner about it (S/R) and he tells you 'that's fine' because it's not the same as saying 'I just took an arterial' or 'there's a complication'. All this is technical, there is nothing psychological you can say."*

Participant 36, male, 26 years old, emergency care, 3° wave: "*It demotivates me (to offer spiritual care) because we don't have time."*

Theme 3: The COVID pandemic and spiritual care

3.a. Ethical dilemma

A total of 81.25 % of the participants denied having experienced an ethical dilemma during the pandemic, that is, patients who refused treatment or care for pneumonia by SARS-COV 2 due to religious or spiritual issues. Among the issues that caused ethical dilemmas in interviewees during the pandemic, they highlighted the limitation of therapeutic effort and avoidance of blood transfusions.

Participant 43, female, 50 years old, emergency care, 3° wave: "*Perhaps we have had many spiritual crises because there were patients who, not the famous intubate or not intubate, but we have wondered what we do with a patient who is really sick, is getting worse and has already had a bad quality of life before? So there have been many morals involved, many spiritualities involved or many religious values involved in healthcare as far as doing everything possible if where are we going? What are we doing?"*

Regarding how health workers faced ethical dilemmas, most agreed that, despite posing a risk to patients, they should accept and respect their decisions as long as the patient had been informed and understood the risks and benefits of accepting or refusing treatment.

Participant 5, female, 25 years old, ICU, 1° wave: *"The first time I was quite surprised [the rejection of a treatment] because I thought "He will die for something that for me is as simple as its religion", I have always respected it, but for me it is something irrational."*

3.b. Rituals of Death

One of the problems caused by COVID-19 pandemic was the isolation of patients and the restriction of family visits. Most of the interviewees agreed that this measure, although necessary, was hard and may have accentuated feelings of loneliness, sadness, anxiety, and/or suffering to patients, family members and even health professionals themselves.

Participant 8, female, 24 years old, ICU, 1° wave: "*I believe that it is one of the greatest handicaps of this pandemic, since the companionship of family members is very comforting to both; and the restriction of visits generates anguish and uncertainty; although we must understand that it is the best thing for all."*

Regarding the presence of spiritual or religious rituals, the most mentioned by the participants were the presence of personal objects, such as stamps or photographs, or rites in the death of relatives. This was limited because entering isolation was allowed only for restricted personnel to avoid contamination and contagion.

Participant 28, female, 28 years old, emergency care and ambulance, 1° wave: "*There have even been relatives who asked you when you went to put the family member in the shroud to leave the cross, he had or the bracelet he had."*

Participant 42, female, 26 years old, emergency care, 3° wave: "*The moment they move into the COVID zone, all that changes. They go to an area where they don't have their belongings, where what they have is the minimum possible, and maybe many don't have a television or anything."*

On the other hand, isolation measures generally did not have any exception, even in end-of-life situations (more in the first wave than in the third). This had an important impact, as it prevented the accompaniment and separation between family and patient. Religious rites such as extreme nurses' union in Catholicism were not offered or were performed less frequently in covid positive patients compared to patients not infected with SARS-COV 2. This situation was described by health professionals as a very difficult experience to live with and they affected themselves in their mood.

Participant 43, female, 50 years old, emergency care, 3° wave: "*It's the toughest part for me, having to let a person die alone, and that the relatives are out alone and that they cannot be accompanied in that trance, in that part of life that is death, because that has been the worst by far. It's the worst thing I've ever been through, I've gone home crying every time about the impotence of not being able to do anything about the deaths in the hospital."*

Theme 4: Training in spiritual care

Most of those interviewed (77 %) considered that spiritual training should be given more value and be included in the healthcare schools as

it would be beneficial to care for and meet all patient needs holistic and comprehensively. They also indicated that they preferred to receive theoretical and practical training. Additionally, health care said that they do not feel formed in spirituality and considered lack of training or ignorance an obstacle to dealing with spirituality with patients.

> Participant 7, female, 22 years old, emergency care, 1° wave: "*Yes, I see it as really necessary [formation in spirituality] because we are caring for patients with many beliefs, and we are not able to cover that need for the patient.*"

Finally, health professionals reflected on the importance of spiritual and/or religious care in their work. A total of 66.7 % considered that spiritual care was of high or very high importance in critical or emergency care since such care could help to deal with bad news or borderline situations in their service.

> Participant 37, female, 23 years old, emergency care, 3° wave: "*I think it is important because it is a service where there is a lot of stress, a lot of adrenaline and you see very shocking things. So, I think it is important to take care of spiritual health.*"

On the other hand, there was another minority opinion current, 27.1 % who considered that spiritual care was not relevant in critical and/or emergency services as biological patient care prevailed.

> Participant 46, female, 30 years old, ambulance, 3° wave: "*If I have life or death care, I will not worry* [about spirituality]. *In case of emergency, there are other priorities*."

Discussion

Our findings revealed that most emergency and critical care nurses believe spiritual care is important to their clinical practice, but there are still several barriers to address patients' spiritual needs, such as lack of training, misconceptions, and lack of time. During the COVID-19 pandemic in Spain, nurses felt that spiritual beliefs have emerged as important needs of patients and the restrictions imposed by the pandemic made health professionals more exposed to ethical dilemmas and end-of-life religious issues. The general impression of nurses is that training is necessary, and more resources should be allocated to this topic.

Regarding the previous conceptions of the participants, 39.6 % of health professionals said they had never heard of the term 'spiritual health' and most of them have challenges to differentiate religion and spirituality. This result agrees with that of some authors in their work, Badanta et al. pointed out that previous studies had identified difficulties in differentiating between religiosity and spirituality among health professionals (Badanta et al., 2022). Despite the lack of conceptualization, most of the participants agreed that spirituality had an influence on the health of patients, helping them cope with the disease or thought that spirituality even influenced the professional-patient relationship. This is also in accordance with previous studies, showing that most health professionals believe spiritual issues are important for patients and should be considered in clinical practice (Kørup et al., 2021; Vasconcelos et al., 2020).

As necessary resources for approaching spirituality in emergency and critical care, the need for time and places that allowed for a spiritual approach and the availability of specialised personnel, such as spiritual guides covering all different religions, was pointed out. Despite this recognition that spirituality should be incorporated in their clinical practice, our study supported that this issue is sometimes underrecognised and not so frequently addressed in emergency and critical care settings. However, some nurses avoided the responsibility of spiritual care justifying that the emergency room was not the place to provide this care, since urgent acute care prevails and should be focused solely on physical and biological issues. This is particularly important if we consider that patients in these environments have acute and life-threatening conditions and tend to use religious and spiritual issues to cope with their conditions. A previous US study has found that 90 % of patients believed that prayer may impact their recovery and 94 % agreed that physicians should ask them whether they have such beliefs if they become gravely ill (Ehman et al., 1999).

In our study, the most common reasons for failing to address spiritual needs were related to lack of time, lack of training, misconceptions, lack of religious knowledge and fear of imposing beliefs. These factors are also fully supported by previous studies (Espinha et al., 2013; Gordon et al., 2018) and seems to be related to the lack of training for these professionals. Addressing spiritual issues do not demand too much time and when training is available misconceptions and the fear of imposing beliefs tend to diminish, as noted in an educational trial that assessed the efficacy of a spirituality training among healthcare students (Osório et al., 2017). Likewise, in our sample, participants alluded to the fact that the knowledge they had about religion was mainly from the Catholic religion, and in clinical practice they encountered several different religions. This problem could be reduced providing training to health professionals as well.

Finally, since our study took place during the pandemic, there were several assertions on the relationship between spiritual needs/beliefs and COVID-19. First, participants noted that there appeared religious dilemmas during the pandemic, mostly related to end-of-life issues and blood transfusions. End-of-life issues are strongly influenced by cultural and religious issues and previous studies have shown that more religious individuals tend to have more aggressive end-of-life preferences (Balboni et al., 2007). Nevertheless, spiritual care at the end-of-life has proven to be associated with less aggressive care at the end of life (Peteet & Balboni, 2013). Concerning blood transfusions, there are patients who refuse blood transfusions for religious reasons, such as the case of Jehovah's Witnesses. For these patients, there are options such as optimisation of hemoglobin levels preoperatively, attention to blood-salvaging methods intraoperatively, minimization of blood draws postoperatively and transfusion alternatives (e.g. hemoglobin-based oxygen carriers) (Rashid et al., 2021).

Another important point reported by participants was the restriction caused by COVID 19, which affected the mood of families and make patients isolated due to the limitation of contact and visits to the family. The feelings that this aroused according to the interviewees were fear, fear, anxiety, frustration, impotence, uncertainty, or agony. The role of spirituality in coping with stressful situations is highlighted here again, since positive religious coping can lead to thinking positively about adverse events and help reduce depressive and/or stressful symptoms (Mahamid & Bdier, 2021). Furthermore, hope could act as a buffer against the anxiety and stress of the virus pandemic caused by the closure of COVID or social distancing (Al Eid et al., 2021). Since such limitations were imposed, religious support suffered important consequences and the religious rituals and needs during hospitalisation were impaired.

Throughout the interviews, feelings of emotional exhaustion were also observed in the nurses, who expressed tiredness, boredom, or detachment. In previous articles, the increase in poor mental health among nurses during the COVID-19 pandemic has already been described, (Kim et al., 2021) described an increase in anxiety and stress among the nurses interviewed during their research. These emotions could suggest the existence of Burnout Syndrome, which is known to be a phenomenon that causes physical, psychological and/or spiritual exhaustion when the worker, in this case the nurses, is subjected to an overload such as pain, death and lack of support from managers (De Diego-Cordero et al., 2022). The latter is compatible with the situation experienced during the pandemic by the interviewees: deaths from COVID, isolation, work overload, lack of resources, etc. Spirituality could have a strong weight in these situations, (de Diego-Cordero et al., 2022) concluded in a systematic review that spirituality or religiosity served as a coping strategy to alleviate burnout in clinical practice and could serve as a health promoter for nurses, helping them rediscover

passion for their profession and life. Kim also noted that nurses with high levels of resilience, spirituality, and family functioning are two to six times less likely to have poor mental health (Kim et al., 2021).

Limitations and strengths

The present study has some limitations that should be considered. First, this study was carried out in Spain and reflects the experiences of health professionals from Spanish health care facilities. It is difficult to guarantee that the same results would be observed in other countries, since cultural and religious backgrounds are different. Second, we used a purposive sample and generalisability should be made with caution. Third, this intervention was carried out during the first and third waves of the COVID-19 pandemic, and these findings could be different in other moments of the pandemic. Finally, our sample consisted predominantly of women (70.8 %). Nevertheless, this feminisation of the sample coincides with what has been pointed out in previous studies that have shown that women are the majority gender in nursing (El Arnaout et al., 2019).

Future studies should evaluate the opinions and perceptions of emergency and critical care health professionals among different cultural contexts, since different societies could have different approaches for the addressing of spirituality. For instance, more secular societies could have more resistance to consider such issues and societies with a predominant religion could have more difficulties in accepting other religious traditions. Another interesting future direction for studies would be to compare the differences between addressing spirituality needs during moments of crisis and social isolation (such as the case of the pandemic) and compare to routine conditions (before or after the pandemic).

Conclusions

In conclusion, most emergency and critical care health professionals believe that spirituality is important to patients' health and believe it could promote faith and hope. Nevertheless, spiritual needs are not frequently addressed in clinical practice due to several barriers such as lack of time, misconceptions and lack of training. According to these professionals, the resources necessary to provide targeted spiritual care are the creation of enabling spaces and the integration of religious personnel specialised in different cultures.

Spirituality plays an important role in people and even more so in patients during the COVID-19 pandemic, improving coping with adverse events and influencing end-of-life issues and ethical dilemmas. The need for spiritual care training is evident, although of low importance since emergency care is understood to be more focused on strictly biological components to overcome the acute and life-threatening emergency.

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CRediT authorship contribution statement

Rocío De Diego-Cordero: Conceptualization, Methodology, Software, Validation, Investigation, Resources, Writing – original draft. **Azahara Rey-Reyes:** Writing – review & editing. **Juan Vega-Escaño:** Methodology, Software, Validation, Formal analysis, Data curation, Writing – original draft, Supervision. **Giancarlo Lucchetti:** Methodology, Software, Validation, Formal analysis, Data curation, Writing – original draft, Visualization. **Bárbara Badanta:** Methodology, Software, Validation, Formal analysis, Data curation, Writing – original draft, Visualization.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.iccn.2022.103373.

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