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Spiritual Care[Givers] Competence in Palliative Care: A Scoping Review

Cristina Raquel Batista Costeira

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Curricular Unit: Dissertation

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Leiria, 2024

“Those who pass by us do not go alone, they do not leave us alone.
They leave a little of themselves, they take a little of us.”

“Aqueles que passam por nós, não vão sós, não nos deixam sós.
Deixam um pouco de si, levam um pouco de nós.”

(Saint-Exupéry, 2001).

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And to all that crossed my path and helped me find myself...

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RESUMO

Os profissionais para prestarem cuidados espirituais devem estar preparados para intervir nas dimensões física, mental, social e espiritual. A competência em cuidado espiritual inclui conhecimento, comportamentos, atitudes e habilidades que permitem um cuidado bem-sucedido ou eficiente. Este estudo teve como objetivos: a) mapear a evidência sobre a competência, nomeadamente o conhecimento, as habilidades, e as atitudes específicas para o cuidado espiritual em pessoas com necessidades paliativas; e, b) identificar os principais desafios e facilitadores para a prestação do cuidado espiritual. Para o efeito, foi desenvolvida uma *scoping review* utilizando a metodologia proposta pela *Joanna Briggs Institute*. Seis bases de dados (Web of Science; MEDLINE/Pubmed; Scopus; CINAHL; MedicLatina e SciELO) foram consultadas durante o mês de setembro de 2023, com atualização em janeiro de 2024. Os 30 artigos resultantes foram analisados utilizando a análise de conteúdo. Os dados obtidos foram categorizados nos domínios cognitivo, afetivo e funcional; e, de acordo com os recursos intrapessoal, interpessoal e transpessoal. Os profissionais de cuidados paliativos lidam com a falta de formação e a escassa preparação para prestar cuidados espirituais. Assim, a competência em cuidado espiritual depende da experiência e desenvolvimento profissionais, da inteligência espiritual (domínio cognitivo), da humildade espiritual (domínio afetivo) e da capacidade crítica e reflexiva (domínio funcional). No futuro, os cuidados paliativos deverão procurar fomentar o cuidado espiritualmente competente. Esta revisão tem o potencial de ajudar a esclarecer a real configuração da competência em cuidado espiritual, e, assim, conduzir a melhorias na capacitação dos profissionais numa prestação de cuidados espirituais efetiva a doentes e seus familiares.

Palavras-chave: competência em cuidado espiritual; cuidados paliativos; educação; prática clínica.

ABSTRACT

To deliver spiritual care, professionals must be skilled in physical, mental, social, and spiritual care. Spiritual care competence includes knowledge, behaviors, attitudes, and skills that enable successful or efficient care. This review aims to identify the scope of competence and the specific skills, knowledge, and attitudes used in providing spiritual care to people needing palliative care, and the main challenges and facilitators. A scoping review was developed using the Joanna Briggs Institute methodology. Six databases (Web of Science; MEDLINE/Pubmed; Scopus; CINAHL; MedicLatina and SciELO) were searched in September 2023, with an update in January 2024. The resulting 30 articles were analysed using a content analysis approach. Information was categorized into three domains: cognitive, affective, and functional (based on three personal resources: intrapersonal, interpersonal, and transpersonal). Palliative care professionals face a lack of training and insufficient preparation to deliver spiritual care. Spiritual care competence depends on professional spiritual development and experience, spiritual intelligence (cognitive), spiritual humility (affective), and having a critical and reflexive mind (functional). In the future, palliative care should seek to improve competent spiritual care. This review could help clarify the real configuration of competent spiritual care and lead to improvements in a professional's empowerment when delivering effective spiritual care to patients and families.

Keywords: spiritual care competence; palliative care; education; clinical practice; review

1. Introduction

Spiritual care is a crucial component of comprehensive and value-driven care and is regarded as an indicator of high-quality care [1–3]. Spiritual care is a subjective and ever-changing concept that is distinct from other forms of care. It arises when professionals recognize the transcendent part of existence and attend to a patient’s perception of reality [4]. It acknowledges and reacts to the human psyche when confronted with significant life-altering occurrences (such as birth, trauma, illness, or loss) or sorrow, and can encompass the desire for purpose, self-esteem, self-expression, religious support, and possibly for rituals, prayer, sacrament, or merely for an empathetic listener. The provision of spiritual care commences by fostering empathetic connections through human interaction and adapting accordingly to meet the needs of individuals [5].

In recent decades, spiritual care has become an important target for health researchers because evidence indicates that spirituality and spiritual care have a positive influence on mental and physical health [6,7], including quality of life, hopefulness, depression and anxiety, and the ability to cope with illness [8].

In palliative care (PC), the spiritual domain has great importance and demands adjusted person-centered care, namely in end-of-life situations, when patients and families are confronted with multiple possible life choices and the inevitability of mortality [9]. To deliver thorough and appropriate care while maintaining moral and ethical principles, the spiritual aspect must be a priority, as it aids individuals in overcoming their anxieties, concerns, and distress, while also diminishing stress levels, fostering the process of recovery, and motivating patients to discover inner peace [10,11].

Providing holistic healthcare is only possible if the spiritual dimension is included [3], especially for people living with a serious illness, raising issues related to the meaning of life, suffering, connection, and transcendence [10]. All dimensions of a person should be considered, since all impact their symptoms and treatment. Evidence suggests that health outcomes are improved by engaging patients, family, and friends in shared decision making [11–13].

The World Health Organization describes spiritual care as an essential domain, although it is still one of the most neglected components of healthcare systems [14]. While PC has always included spiritual care, its provision and inclusion in clinical care are still insufficient to meet patients’ and families’ needs [15,16]. Several studies demonstrated that patients’ expectations of spiritual discussions in the healthcare setting are not being met. Caregivers highlighted barriers such as work overload; lack of training and practical experience; deficits in self-knowledge and self-awareness regarding spirituality; “lack of spiritual support in

multicultural and multireligious populations, multiculturalism poses challenges to providing spiritual care” [13] (p. 1); communication barriers; lack of attention by organizational managers to the importance of holistic care; motivational fences; blocks in interprofessional collaboration; environmental conditions; late referral for PC; and uncontrolled physical symptoms [13,17-20]. The existence of multiple religious and spiritual practices leads to greater difficulties for healthcare professionals in providing effective spiritual care [21,22]. Moreover, its operationalization has divergent meanings and practices across countries [23,24]. The diversity of religious or spiritual viewpoints has been brought about by secularization, migration processes, globalization, and the emergence of new forms of spirituality and hybridity [25].

The importance of having caregivers who possess spiritual care competence has been highlighted in several countries and cultures [26-28]. According to recent studies, there is a correlation between the spiritual care competence of caregivers and their spiritual health and performance in providing spiritual care to patients and meeting their spiritual requirements [26]. Watson’s Transpersonal Caring-Healing Theory [29] highlights the caregiver’s deliberate purpose in providing care, which might potentially strengthen the caregiver’s healing presence. This theory also recognizes the healing effects of transpersonal relationships and underlines the need to deliver care holistically. According to Anandarajah [10,30] spiritual care competence integrates (a) knowledge (encompassing comprehension of spirituality and religion, the integration of spirituality and belief in patient care, and familiarity with relevant resources and literature); (b) skills (encompassing assessment and therapy; effective communication and listening; and the ability to provide compassionate presence, deliver holistic spiritual care, and navigate differences in belief); and (c) attitudes (encompassing respect, spiritual self-awareness, self-care, and a focus on spiritual well-being).

Providing spiritual care requires trained caregivers [10]. In this sense, knowing what is expected from a caregiver could encourage managers and curriculum planners to promote, through education and training, the spiritual ability and competence of students and caregivers in delivering spiritual care [31-35].

The essence of spiritual care is being rather than simply doing [36], which may be transformational for both the client and the professional. Therefore, in spiritual care, it is not only care provision that holds significance, but rather the incorporation of compassion and spirituality that contribute to the provision of comprehensive care. To date, the systematizations of indicators of competent spiritual care development and evaluation are scarce. To address this gap, this review sought to identify the scope of competence; the specific skills, knowledge, and attitudes used in spiritual care of people needing PC; and the main challenges and facilitators in its provision. In response to growing interest in spiritual care,

we hope to offer a comprehensive framework of what configures appropriate and competent spiritual care.

2. Materials and Methods

2.1. Research Question

This study investigates the following:

1. What is the scope of competence of professionals providing spiritual care to people needing PC?
2. What indicators of knowledge, skills, and attitudes are needed for the delivery of spiritual care?
3. What challenges and facilitators have been linked to the provision of appropriate and competent spiritual care?

2.2. Study Design

This review is part of a larger study contributing to valuing spiritual care in PC through the development of Iberian guidelines for spiritual care competence [37]. In this stage, a scoping review was carried out to find answers to the research questions with the aid of a health sciences librarian. This approach aims to summarize available evidence and map knowledge about a given concept of interest [38]. The pre-established five steps were: (i) formulation of the research question; (ii) identification of relevant sources of evidence; (iii) selection of sources of evidence for inclusion; (iv) data collection/extraction; and (v) grouping, summarizing, and reporting results [39].

The authors developed a search strategy and protocol. The research team comprised nursing faculty members (C.C., A.Q., and C.L.), nursing researchers (F.V. and H.L.), and one occupational therapist (J.S.). Two of the authors have significant experience in providing spiritual care to people needing PC, and three are experienced researchers in PC.

The review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) [38,40] [**Appendix A**]. The study protocol was registered in the Open Science Framework platform (doi:10.17605/OSF.IO/95RSG accessed on 10 April 2024).

2.3. Eligibility Criteria

Using the JBI framework for scoping reviews [41–43], the team of reviewers collectively established a set of criteria for determining which records to include and exclude. They then applied these criteria to the records obtained from searches conducted on various databases

and platforms. The Population/Concept/Context (PCC) framework was used to formulate the eligibility criteria, as depicted in Table 1. The publications were limited to peer-reviewed primary and secondary research published in English, Portuguese, and Spanish. There were no limitations on the choice of time or study design. This review did not include any comparative or control measures.

Table 1. Eligibility criteria.

PCC framework	Inclusion criteria	Exclusion criteria
Population	All papers with reference to the spiritual care competence of PC professionals;	All papers about healthcare recipients (e.g., patients and families).
Concept	All papers exploring spiritual care competencies (knowledge, skills, and attitudes);	Papers that discuss related sub-elements of spirituality (such as connectedness) with no reference to spiritual care.
Context	All papers focusing on spiritual care education and/or practice;	All papers without reference to PC.
Format	Primary studies (quantitative, qualitative, and mixed methods); literature reviews; and reports, guidelines, and other technical publications by professional regulatory agencies, professional groups, scientific societies, or other organizations that have acknowledged authority and standing in the field of PC.	Editor letters; opinion papers; editorials.

2.4. Search Strategy

In the first phase, on 19 July 2023, a limited search was conducted on Medline via PubMed. Table 2 shows the search strategy used in the MEDLINE database—using truncation and operators (Boolean OR and AND)—to analyze the subject headings and keywords in the titles and abstracts and plan a subsequent search. In the second phase, in September 2023 and an update in January 2024, a search was conducted in six databases [Web of Science; MEDLINE via EBSCO; Scopus; CINAHL via EBSCO; MedicLatina via EBSCO; Scientific Electronic Library Online (SciELO)]. The search strategies were adapted to each database. Finally, in the third phase, the reference lists of the included studies were transferred to the Rayann software® (<http://rayyan.qcri.org>) and analyzed.

Table 2. Search strategy used in Medline via PubMed.

	TITLE-ABS-KEY
	(MH "Nurs*") OR (MH "Health Personnel") OR (MH "Chaplain*") OR (MH "Psycholog*") OR (MH "Social Worker*") OR (MH "Counselor*") OR (MH "Physical Therapist*") OR (MH "Occupational Therapist*") OR (Carer*) OR "Spiritual assistant" OR (MH "Caregiver*") OR (MH "Palliative Medicine")
AND	"Spiritual care competence" OR (MH "Spirituality") OR "Spiritual learning outcomes" OR "Spiritual training skills" OR (meaning (life OR death)) OR "faith" OR religi*
AND	(MH "Palliative Care") OR (MH "Hospice and Palliative Care Nursing") OR (MH "Palliative Medicine") OR "end of life" OR (MH "Hospice Care") OR (MH "Hospices") OR "community end of life" OR "palliative assistance" OR "last days and hour of life" OR (MH "Terminal Care") OR (MH "Ambulatory Care") OR "limited life" OR palliati* OR hospice* OR dying

MH—MeSH terms; * truncation

2.5. Study Selection

The records (n = 115) were exported and uploaded to Rayyan® software (Qatar Computing Research Institute, Doha, Qatar). Two independent reviewers screened the titles and abstracts, using the predetermined inclusion and exclusion criteria, and then eliminated duplicates. Eligible studies for review (n = 52) advanced to the second stage and were read in full by two independent reviewers, who confirmed their eligibility using the predetermined standards. The two screening phases included a standardized report on reasons for exclusion. A third reviewer intervened to resolve disagreements between the other reviewers. When there was inadequate or questionable information in the article, the corresponding author was contacted; if the author did not answer and the information requested was essential to validate the data to be retrieved, the study was not included.

The total number of records detected, the reports included and excluded, the reason for exclusion, and the documents included after manually reviewing the reference lists are displayed in the PRISMA flowchart (Figure 1).

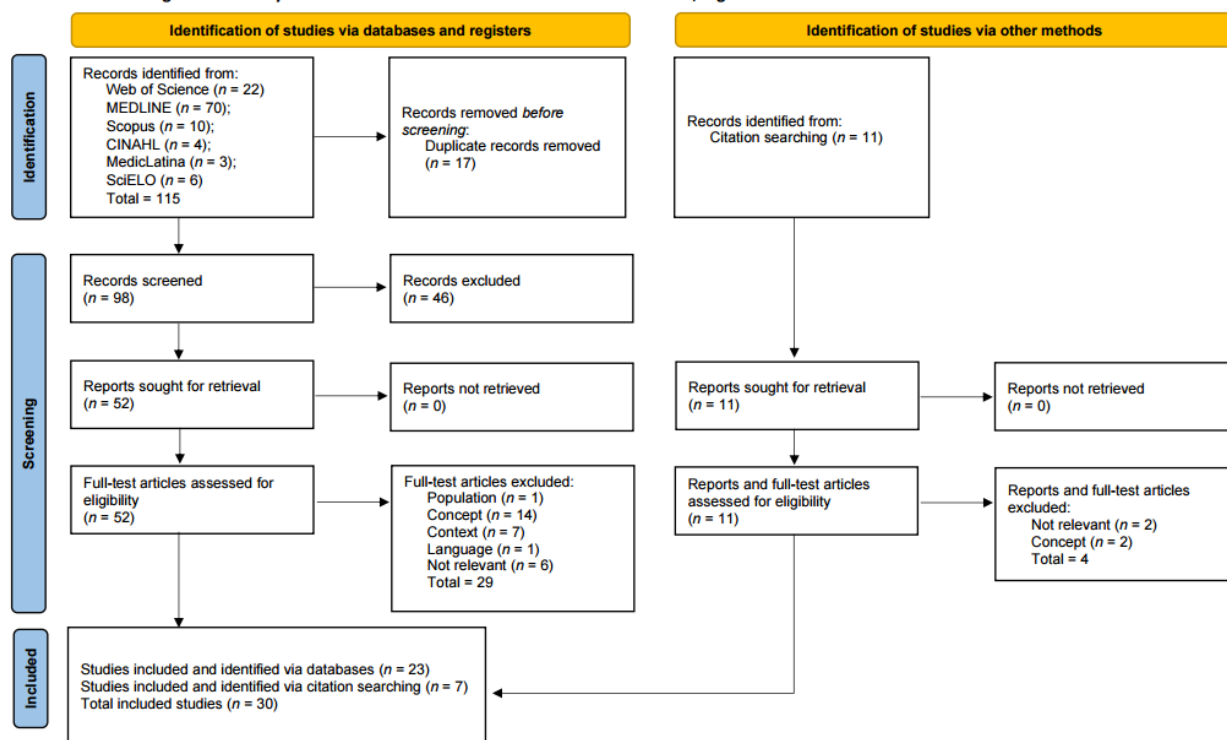


Figure 1. PRISMA-ScR flowchart for identifying, screening, and selecting the articles included in the scoping review.

2.6. Data Extraction

Data were extracted with an instrument developed for this purpose by the authors, using Microsoft Excel®. Data were extracted and synthesized by two pairs of authors independently (C.C., H.L. and F.V., J.S.). Any disagreements between authors were discussed/analyzed with a third reviewer (J.C. or C.C. depending on the pair of researchers).

For each included study, the following data were extracted: title; authors; year of publication; country; type of study; indicators of spiritual care competence (cognitive domain, affective domain, and functional/instrumental domain); and main findings. In Appendix B is summarized the data extracted except the competence indicators presented in Table 3.

2.7. Data Synthesis and Reporting

A third reviewer aggregated all the extracted data into a single document. The descriptive data from the included studies were presented in tables using descriptive statistics. A qualitative content analysis was used to synthesize the textual elements, resulting in a coding structure that, through a deductive approach, led to the categorization, classification, and

association of the information according to similarity and thematic affinity [44,45]. In our analysis, the deductive coding was derived from the Spiritual Care Competence Scale® [SCCS] [46], the EPICC Spiritual Care Competency Self-Assessment Tool® [5,47], and the spiritual support model proposed by the spirituality working group of the Spanish Palliative Care Society (SECPAL) [48]. In this sense, this review used the three domains of spiritual care competence: (a) cognitive; (b) affective; and (c) functional (based on three resources: intrapersonal, interpersonal, and transpersonal). The included studies were not submitted to critical appraisal because the goal of this type of study is to identify gaps in the literature and propose potential research questions for systematic reviews [45].

Table 3. Indicators of spiritual care competence and the studies in which they were identified.

	INTRAPERSONAL RESOURCES [48]	INTERPERSONAL RESOURCES [48]	TRANSPERSONAL RESOURCES [48]
Cognitive (Knowledge) – Assessment and planning of spiritual care [5,47]	Understanding the concept of spiritual care [5, 27,36,47,49-65]	Awareness of different approaches to spiritual assessment [21,27,36,47,50-55,59,61,62,65-68]	Integration of being human into the evolutionary axis of its existence [5,21,46,47,50,53,58,59]
	Understanding the impact of personal values and beliefs in providing spiritual care [5,21,36,47,51-53,59,68-69]	Understanding other professionals’ roles in providing spiritual care [36,47,53,61,63,67]	Problem-solving-‘solution-seeking’ through the caring process of knowing/being/doing/becoming) [5,21,46,47,49-51,53,61,63-65]
	Explaining, to oneself and others, the impact of spirituality on health and well-being across one’s lifespan [5,21,26,36,47,59,63,65,68,70]	Understanding the concept of compassion and presence and its importance in spiritual care [5,46,47,53,54,63,67]	
		Knowing how to respond appropriately to identified spiritual needs and resources [21,36,47,50,51,53-55,59,61-63,65,69]	
		Knowing how to evaluate whether spiritual needs have been met [47,51-55,58,59,61,63]	
	Understanding the ways that people express their spirituality [26,36,47,49,51,53,55,61,65]		
	Awareness of the different world/religious views and how these may impact people’s responses to key life events [5,36,46,47,49-51,53-55,61)		
Affective (Attitudes) – Self-assessment, personal support and patient counseling-, attitude towards patient spirituality [5,47]	INTRAPERSONAL RESOURCES [48]	INTERPERSONAL RESOURCES [48]	TRANSPERSONAL RESOURCES [48]
	Willing to explore personal, religious, and spiritual beliefs [21,26,47,50,52,57,64,68,70]	Being trustworthy and respectful of people’s expressions of spirituality and different world/religious views [5,47,49-51,53,59,61-65,71,72]	Developing and sustaining loving, trusting, and caring relationships [5,63]
	Respecting and being open to people’s diverse expressions of spirituality [47,49-51,53,55,59,61,64,73]	Being open, approachable, and non-judgmental [5,21,46,47,49,50,53,55,59,61-63,65,66,72]	Creating a healing environment at all levels; a subtle environment for energetic, authentic, and caring presence [21,46-51,53,54,57-59,61,63]

		Being compassionate and being present [21,47,49,50,53,54,59,61,63,67]	Being open to spiritual, mysterious unknowns; allowing for miracles [5,21,46-48,50,57,58,63]
		Willing to deal with emotions [47,50,53,61,63,64]	
		Willing to collaborate with and refer to others (professionals/non-professionals) when providing spiritual care [5,46,47,50,53,61,63,67]	
		Welcoming, accepting, and showing empathy, openness, professional humility, and trustworthiness when seeking additional spiritual support [47,49,50,53,54,59,61,63-65,67]	
	INTRAPERSONAL RESOURCES [48]	INTERPERSONAL RESOURCES [48]	TRANSPERSONAL RESOURCES [48]
	Reflect meaningfully upon own values and beliefs and recognize these may be different from other people's [47,53,59,61,68]	Recognizing the uniqueness of people's spirituality [47,49-51,53,57,59-61,63,64,68]	Develop transpersonal experiences such as mindfulness, yoga, visualization exercises, mental relaxation, making mandalas, body awareness activities, therapeutic writing, etc. [21,48,50,54,56,60,61,63,66]
Functional/Instrumental (Skills) – Intervention and evaluation of spiritual care/communication strategies used to support [5,47]	Taking care of personal well-being [5,26,47,48,52,60,64,68,70]	Interacting with and responding sensitively to people's spiritual diversity [21,36,47,49-51,53,55,58,59,61,63,65,67,73,74]	Develop interventions to sustain human dignity [5,21,30,36,46-55,56-58,60-68,69-74]
	Demonstrate spiritual self-awareness [48,53,66,73]	Listening skills (verbal and non-verbal practices) [5,21,36,46-49,50,53,54,58,59,61,63,64,67]	
		Group communication, conflict resolution, negotiation, and goal clarification [36,48,49,53,61,64]	
		Conducting and documenting a spiritual assessment to identify spiritual needs and resources [5,46-51,53,54,56,58,61-64,66,71,73]	
		Collaborating with other professionals" in the provision of spiritual care [21,47,50,53,67]	

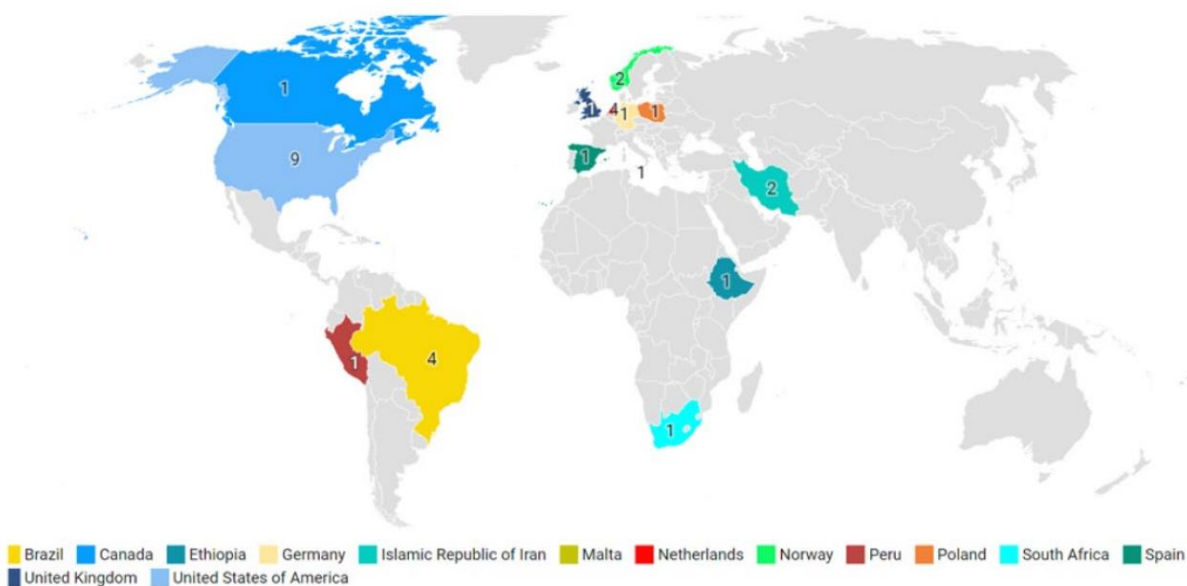
		<p>Containing and dealing appropriately with emotions [21,47,50,53,61,67,74]</p> <p>Recognizing personal limitations in spiritual caregiving and resorting to others when appropriate [21,46,50,62,67,68,72,73]</p> <p>Using evidence-informed practices to help patients and families address fears and spiritual and other distress related to life-limiting and end-of-life care [5,46-48,50,53,55,58,61]</p> <p>Applying culturally appropriate, evidence-informed strategies for communicating with patients and families about pain and suffering, loss, complicated and anticipatory grief, and life review [5,46-51,53,55,59,61,63]</p> <p>Evaluating and documenting personal, professional, and organizational aspects of spiritual care, and reassessing appropriately [47,49,51,53,61,65]</p>	
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3. Results

The initial search retrieved 115 articles. After removing 17 duplicates, the remaining 98 articles were reviewed by title and abstract, and 46 articles were excluded. The full review was performed on 52 articles. Among these, 29 were excluded because they did not align with the study criteria. Eight additional articles were retrieved by searching article bibliographies. In the end, a total of 30 articles were included in the scoping review. The results of the search are shown in a flow diagram (Figure 1).

All retrieved studies were published between 2007 and 2022. Most of the articles were primary studies ($n = 19$), published in 2022 ($n = 7$), and written in English ($n = 25$). Studies were developed with health professionals delivering PC in different clinical contexts ($n = 19$), education/formation in PC ($n = 6$), and specialized PC services ($n = 5$). The country that contributed the largest number of studies was the United States of America ($n = 9$) (Figure 2).

Figure 2. Geographic distributions of studies included in the scoping review.



The data extracted from the included studies were categorized into three domain categories: cognitive, affective, and functional.

In the cognitive domain, the imperative lies in the assimilation of knowledge that helps professionals formulate a thorough spiritual assessment and tailor a customized spiritual care plan. In the affective domain, professionals need to show a predisposition towards executing proficient spiritual care and be equipped with the necessary tools to achieve personal emotional balance, thereby ensuring the delivery of spiritual care that satisfies the needs of the patient and their family. In the functional domain, professionals must demonstrate

competencies that empower them to lead supportive interventions and conduct evaluations of effective spiritual care within the clinical practice context (Table 3).

For each of these domains, the professional should engage intrapersonal, interpersonal, and transpersonal resources. This not only enables them to deliver proficient care to patients and their families but also fosters the development of their spiritual well-being.

The results presented in the subsequent sections were organized according to the cognitive, affective, and functional domains. This organization is rooted in the analysis of data extracted from the articles included in the review, with each domain serving as a framework for categorizing and discussing the extracted information.

3.1. Cognitive Domain

In the cognitive domain, professionals are expected to acquire and retain knowledge that enables them to comprehend, articulate, and be aware of the nuances of spiritual care [47].

In the realm of intrapersonal resources, professionals are expected to leverage their knowledge to recognize the importance of spirituality in influencing health and well-being. There is consensus in the reviewed literature about the criticality of comprehending spiritual care, acknowledging the variability across different cultures and individuals, and elucidating the profound effects that these variations have on health and well-being throughout the human lifespan. The studies underscore the multiplicity of spirituality definitions, which are inherently subjective and shaped by an individual's age, experience, and cultural background [26,27,49–51,53,59,61]. This diversity complicates the establishment of a universally accepted spiritual care competence and interferes with expected and delivered spiritual care. The ability to differentiate between spirituality and religion is deemed crucial [54,60] to understand and articulate how personal spiritual experience influences the delivery of spiritual care [21,26,51,53,59,68,69]. This skill extends to defining key concepts such as PC, religion, spirituality, and spiritual care itself, as suggested by Dezorzi et al. [55], thereby enriching the professional's capacity to provide nuanced and culturally sensitive spiritual care.

In the cognitive domain, interpersonal resources pertain to proficiency in engaging with the person's spiritual dimension, while acknowledging the diversity of spiritual and cultural worldviews, beliefs, and practices [47]. Professionals must take various approaches to spiritual care, comprehend the roles of other professionals in this realm, and grasp the significance of compassion and presence in the provision of spiritual care. Professionals should be capable of appropriately identifying spiritual needs and resources, assessing the fulfillment of these needs, understanding the diverse expressions of spirituality, and considering how the varying

global and religious perspectives might influence individual responses to significant life events [50].

Furthermore, professionals are tasked with discerning whether patients have a restful form of religiosity that is deeply integrated and supportive during health challenges, or if conflicts within their belief system may arise [52]. The availability of instruments to assess the dimensions of spiritual care is crucial in enabling professionals to devise a targeted plan to address spiritual care needs effectively, thereby facilitating competent spiritual care delivery [27,48–52,55,68].

Lastly, professionals with transpersonal resources are expected to have the capability to assess and address spiritual needs and resources, fostering the integration of the human experience within a broader evolutionary context, and thus cultivating an awareness conducive to problem-solving and the provision of compassionate care [36,50,61]. It is important to acknowledge that human existence is intrinsically linked to the individual and communal pursuit of meaning, purpose, and transcendence [50]. This pursuit is characterized by how individuals connect with the present moment, themselves, others, nature, and the significant or sacred realms, thereby underscoring the holistic nature of human life [36,50,51,61].

3.2. Affective Domain (Attitudes, Behaviors)

The affective domain encompasses the emotional aspects of spirituality, focusing on the attitudes and behaviors that influence the interactions between professionals and patients. Within this domain, it is crucial to cultivate a trusting therapeutic relationship, which is foundational to effective practice. A compassionate disposition, characterized by empathy and a genuine concern for the well-being of others, involving passion and love, is essential in this domain [50,60]. Such compassion transcends mere sympathy, inviting a deep engagement with the patient's experience of suffering, thereby enabling healthcare professionals to provide care that is not only empathetic and devoid of pity but also deeply attuned to the needs of patients and their families [50].

In this domain, it is critical to integrate ethical reasoning: respecting a client's decisions about their well-being; avoiding judgmental attitudes; being a reflective caregiver; sustaining the ability to contain/tolerate ambiguity; developing a tolerance for sadness capable of empathizing with the suffering of others; exhibiting spiritual humility; and realizing that it is not easy to answer all questions and that quick solutions are not always possible, demanding a mutual search of meaning [21,53,61].

A person's capacity for ethical thinking must be developed, as human nature strongly leans toward egotism, prejudice, self-justification, and self-deception [61,75].

Sometimes people confuse ethics with behaving according to social conventions, religious beliefs, and the law, but ethics is a domain unto itself, with universal principles and concepts that are transcultural and trans-religious [61,75].

In the affective domain, the professional's intrapersonal resources pertain to cultivating mechanisms and tools for self-exploration to deepen their understanding of their personal beliefs and values [52]. This introspection is critical for discerning what holds significance for them, thereby enhancing their capacity to deliver spiritual care that is both pertinent and efficacious [52]. Moreover, the ability to reflect on one's attitudes and approaches to various situations fosters a heightened awareness of one's values, biases, and emotional responses. Such self-awareness is instrumental in recognizing the complex interplay between the feelings, beliefs, and values manifested in interactions with others, which is essential for the provision of effective spiritual care [50].

Professionals are expected to provide open and respectful spiritual care that acknowledges the diverse expressions of spirituality among individuals (i.e., interpersonal resources). Benito et al. [50] describe a model wherein attitudes of hospitality, presence, and compassion help patients and their families in their spiritual awakening. In this model, hospitality refers to the ability that professionals should develop to break the narrowness of their fears and allow a stranger in. Presence implies being deeply there for the patient and their family. Compassion is the attitude of demonstrating a truly active interest in a patient's suffering, showing a continuing determination to do everything possible to relieve their suffering [50].

This demands a personal and professional development of empathy and compassion [54]; approachability and presence [55]; kindness and attentiveness [52]; sensitiveness, a non-judgmental posture, a reflective practice, an ability to manage ambiguity and tolerate sadness and courage when facing the suffering of others, humbleness [53], and trustworthiness [53,59].

Transpersonal resources highlight the importance of recognizing the interconnection between physical, emotional, and spiritual dimensions. The emphasis relies on the significant roles that faith and hope play in people's lives, especially in the face of life's uncertainties and challenges, such as illness, pain, stress, despair, sadness, fear, and death [21].

The deeply spiritual nature that characterizes us—as beings interconnected with ourselves, others, and the universe—is a dynamic experienced on a transrational, transpersonal, and transconfessional level [50].

3.3. Functional Domain (Skills)

The functional domain concerns the practical aspects of spiritual care, including the implementation of interventions and the effective evaluation of such care in clinical practice. This domain is critical for demonstrating competence in clinical care provision, which includes assessment, planning, intervention, and evaluation.

Professionals must manifest spiritual self-awareness, encompassing an understanding of both their personal values and beliefs and those of others, while also ensuring their well-being (i.e., intrapersonal resources). This self-awareness enhances the ability to provide competent spiritual care, drawing on personal knowledge and both own and observed spiritual experiences [73]. Personal well-being serves as a fundamental element in PC settings, where professionals frequently encounter challenging scenarios. Therefore, the development of strategies aimed at enhancing personal well-being and reframing emotionally charged experiences, such as spiritual distress among terminally ill patients, is imperative [70].

Interpersonal resources involve the adoption of behaviors that respect the uniqueness of people's spirituality, aligned with an interaction with sensibility. When professionals interact and respond to patients, sharing their vulnerability and their transcendental experience, they help patients cross the bridge from suffering to acceptance and surrender, towards transcendence and with it to "spiritual healing", which refers to the person's ability to find solace, comfort, connection, meaning, and purpose amid suffering, heartbreak and, pain [50]. Through compassionate interventions, the sufferer transcends to a different space characterized by growth and a more mature vision of reality [50].

These resources encompass the use of proficient communication strategies to facilitate the provision of effective spiritual care. From this perspective, professionals are expected to engage with patients and their families through assertive communication regarding spiritual or religious matters, characterized by both acceptance and sensitivity. Professionals must establish objectives that align with the spiritual or religious perspectives of patients. Furthermore, this requires adapting therapeutic approaches to incorporate the spiritual or religious viewpoints of patients, based on evidence [49].

The reviewed literature acknowledges the importance of recognizing personal limitations in spiritual care and refers to multidisciplinary professionals, since spiritual competence is developed differently among professionals and not all are prepared to deliver it [50,61].

In the domain of transpersonal resources, professionals are anticipated to foster and engage in transpersonal experiences that uphold human dignity and respect the autonomy of patients. The research underscores the significance of incorporating self-reflective practices

such as journaling, prayer, meditation, and artistic endeavors [36,50]. These activities reflect the commitment to explore the emotions, beliefs, and values of others, thereby facilitating personal and communal growth. Activities may include engaging in prayer, studying spiritual texts like the Bible, practicing active listening, providing comforting verbal reassurances, ensuring a consistent and supportive presence, coordinating visits from spiritual leaders, and personalizing care with gestures like nail painting for special occasions. Additionally, the introduction of therapeutic interventions such as music, massage, therapeutic touch, and mindfulness practices are highlighted [21,54,61,66]. Such comprehensive care, which attends to both basic and spiritual needs, establishes a healing environment that encompasses both physical and metaphysical elements, thereby exemplifying proficient spiritual care within this domain [21].

3.4. Novice–Expert Continuum

The capacity to provide tailored interventions that suit each client and enhance their sense of self-worth is a key aspect of spiritual care competence, which is an active and continuous process. Spiritual competence is situated on a continuum extending from spiritually negative to spiritually competent practice, which requires reflection on experience. This continuum is similar to Benner's [76] continuum from novice to expert. A collection of abilities, attitudes, and knowledge that may be acquired via practice and education throughout time defines this competence continuum. For Baldacchino [77], professionals providing spiritual care should exhibit characteristics such as (a) role modeling for junior caregivers; (b) education on spirituality, integrated into undergraduate and postgraduate course programs; (c) reflection in and on the action; (d) vocation, or responding to a spiritual call; (e) taking initiative for active presence in care; and (f) commitment towards the delivery of spiritual care. To achieve the adage of "Being in Doing", spiritual humility, spiritual intelligence, reflection, and critical incident analysis are indicators of competence from novice to expert [36]. Humility as a "teacher of all virtues" impacts the relational functioning of dyads, groups, and communities [50,53,78]. It has been associated with generosity, empathy, quality social relationships, spiritual maturity, and graciousness in receiving from others [78]. Wright et al. [79] asserted that the core of humility should best be described as "a particular psychological positioning of oneself—namely, one that is both epistemically and ethically aligned." Both intrapersonal and interpersonal dimensions of humility allow professionals to (a) cultivate healthy and mature relationships and (b) develop mature forms of "alterity" or socially just and mature ways of relating across human differences.

Furthermore, learning via reflection while acting is crucial since it enables one to assess one's actions, enhance patient care, and acquire the essential skills [80,81]. Metacognition skills are crucial for spiritual intelligence because they enable the identification of self-actualizing wants and objectives and help direct one's personal efforts toward these objectives. Professionals who possess metacognition are also better able to learn from their experiences, become conscious of their thinking, and have a firm understanding of who they really are—all of which are essential components of a reflective mind. The goal of both spiritual intelligence and metacognition is to fulfill an individual's ability to increase their knowledge of their existence, including psychological components like self-perception, self-experience, and self-control [61,82].

3.5. Challenges and Facilitators Associated with the Provision of Appropriate and Competent Spiritual Care

The included studies predominantly indicate a lack of training concerning the integration of spiritual and religious considerations within the cognitive, affective, and functional domains of care. This is particularly evident in the context of developing the ability to discern when and how to engage with patients in a supportive manner (even under challenging circumstances, such as delusional states or crises), thus underscoring the imperative for clear guidelines [52,65]. Another challenge includes the lack of knowledge related to religion and the other deeply held beliefs of various people groups. Likewise, spiritual self-analysis may be a struggle, as staff can feel inadequate in delivering spiritual care and interdisciplinary communication may be inconsistent [83].

To address this shortfall, ongoing education is deemed critical for equipping PC professionals with the requisite skills to implement a holistic and person-centered care model that prioritizes the patient–family unit and incorporates spiritual care needs into the decision-making process and bereavement support [55,74]. Compassion and empathy are core values in delivering high-quality, person-centered care. These essential values can be fostered through various reflective practices, including individual and group reflection, case discussions, written exercises, debriefing sessions, simulation activities, role-playing, and shadowing other experienced professionals in the multidisciplinary team, thereby enhancing professionals' proficiency in compassionate engagement and spiritual level [54,62,64]. It is recognized that professionals must proactively pursue personal and experiential learning opportunities to update and expand their spiritual knowledge base [60]. Evidence also suggests that 'spiritual intelligence' can affect the spiritual care competence of students by promoting a high level of critical thinking and spiritual self-awareness [84].

Furthermore, the development of competencies in spiritual care is highlighted as a crucial aspect of training programs [68]. The acquisition of such competencies relies on diverse pedagogical methods, depending on the individual's spiritual awareness and experiential learning. Some strategies such as self-reflection or journaling, reflection in small groups, and managing spiritual or religious conversations are opportunities for spiritual care training. Involving a spiritual assistant in simulated learning was also well received [36,83].

Mächler et al. [69] emphasized the interrelationship between an individual's spirituality and their professional conduct and their competencies in spiritual care, which significantly influences both patient outcomes and professional development [69]. This interplay demands careful consideration by healthcare administrators and PC professionals when structuring care delivery, organizing the workplace, and creating conducive environments for the practice of spiritual care [71].

The significance of a supportive environment in the provision of spiritual care is also highlighted, particularly in ensuring privacy and confidentiality during sensitive discussions (i.e., room or place where others can overhear the conversation), which extends beyond structural or organizational dimensions [52].

4. Discussion

The main purpose of this study was to scope the competence of professionals providing spiritual care to people experiencing PC needs. In this regard, it is important to differentiate two interchangeably usable concepts: competence and competency. Competence is the ability to do something successfully or efficiently and is a state of being prepared to do a job. In contrast, competency is usually described as an action, focusing on an individual's actual performance in a particular situation (i.e., competence is what we do, and competency is how well we do it) [85].

This review proposes three important domains of spiritual care competence: cognitive and spiritual intelligence; spiritual humility; and effective and critical reflection, where the professional shows the ability to learn with continuous critical reflection through spiritual experiences. These three domains must be present for spiritual competence and are seen as a process of permanent development, with different levels until one becomes an expert. To attain competence as an expert demands that professionals have high cognitive ability (i.e., spiritual intelligence), a favorable attitude towards spiritual issues (i.e., spiritual humility), and a critical functional domain (i.e., reflective mind and metacognition) that could help them use spiritual intelligence in everyday problem-solving and efficiently satisfy the spiritual needs of patients [17,78,86,87].

As spiritual beings, we all need spiritual care in our life path. This is more evident in end-of-life situations or circumstances that induce reflection about life's meaning, as frequently occurs in those needing PC [50,61,88]. Despite this, professionals consider spiritual care as an important but neglected aspect of healthcare [48,54,88]. Although spiritual accompaniment should be provided to all patients, namely those in the process of dying, not all professionals can do it efficiently. Spiritual care requires more than the accumulation of knowledge, demanding one be spiritual in personal and professional life [50]. This allows increased self-awareness, empathy for the client's perspective, and the capacity to carry out tailored interventions that are suitable for each client [36].

This process begins by recognizing the importance of spiritual training to personal and professional spiritual development. There is a lack of professional training and a nonconsensual structure in the curriculum of healthcare professionals, although studies show that educational and training programs are efficient strategies for developing skills and promoting competent spiritual care [36,67,89–91]. Techniques like role-playing, focus groups, reflective writing, mentorship programs, discussions on the observed delivery of holistic care, the use of art to express complex spiritual care concepts, involvement in research, tutorials, role-modeling, experiential learning, and community visits could also be beneficial in developing competence and learning in spiritual care [36,92]. Therefore, it is recommended that all PC training and curriculum incorporate spiritual care activities, because these enable caregivers to grow spiritually and better help others in need of spiritual guidance [93,94].

The lack of knowledge about spiritual care limits competent spiritual care [95]. It is also known that the knowledge obtained through continuous training can help professionals blossom their spirituality. The studies in this review suggest that professionals with more self-awareness of spirituality were more well prepared to deliver competent spiritual care [53,66,73]. Knowing more and the best of oneself is essential to align one's work with the PC philosophy and find a balance between giving and receiving [96]. However, training and education are not the only aspects that interfere with spiritual development and spiritual care competence.

A diversity of personal and spiritual conceptions, experiences, and personal characteristics (i.e., age, and cultural belonging) compete for different approaches and priorities in spiritual care delivery. Spirituality is related to culture and plays a vital role in the treatment provided to patients [60]. Variables such as age and spiritual care training were significantly associated with competent spiritual care [26,27]. López-Tarrida et al. [97] agree with that idea and add gender as relevant to how spiritual care is delivered. The authors defend that women are more proficient in distinguishing between spirituality and religion and more

self-aware of other's needs [97]. This aspect could be explained by education and traditional gender differences, depending on different aspects of the environment (contextual); on patients' beliefs, experience, and current conceptions; and on family issues, professional experience, personality, knowledge, skills, and attitudes. All these will affect the process of delivering spiritual care and how spiritual care competence is conceptualized.

Competent spiritual care must involve the cognitive, affective, and functional domains, which are interconnected and mutually influence each other, encompassing one unique competence in spiritual care. Although the instruments to assess spiritual care competence defend the existence of several competencies, this review highlights the idea that these three domains must be developed to provide competent spiritual care [46–48,50]. The domains are not necessarily on the same level and allow the development of specific skills, values, attitudes, beliefs, behaviors, and knowledge, through the mobilization and development of three main resources: intrapersonal, interpersonal, and transpersonal specificities. The idea is based on the assumption that PC professionals must develop those domains (over several stages) to competently respond to the spiritual needs of the patient/family, suggesting an active, dynamic, and continuous process, enhanced and deepened with experience and training.

This process is an indicator of competent spiritual care and the professional's ability to promote person/family-centered care. It is well known that a person-centered practice brings a positive impact, since it promotes sustainable healthcare systems and high care quality [98]. With competent spiritual care, patients and families experience a sense of "healing" where they can find comfort, security, meaning-making, and closure in PC [50,99]. Thus, delivering competent spiritual care is an integral part of PC, where supporting relationships should be a central focus [50,100]. Spiritual care is characterized by the provision of a healing presence, therapeutic use of self, intuitive sense, spiritual viewpoint exploration, person-centeredness, meaning-centered therapy intervention, and the development of a spiritually nourishing atmosphere [4,50].

4.1. Strengths and Limitations

One of this review's merits is the adoption of thorough, open procedures that were followed throughout. The methodology was examined by a research team with experience in scoping reviews and PC knowledge. Six electronic bibliographic databases were searched, together with the snowball method for further research and reports, thus guaranteeing a thorough search of the literature. Furthermore, the models that support the deductive analysis were based on an anthropologic and transconfessional spiritual care approach. This means we welcomed different cosmovisions rooted in our primordial awareness of the human spirit.

Apart from the limitations inherent to the chosen method, this literature review was also limited by its biased cultural representation among the included studies, providing a perspective of spiritual care competence focused on the occidental worldview. This could limit a full understanding of spiritual care competence in a world that is increasingly global. Most studies were carried out in Western nations, focusing on groups that have similar characteristics and come from a largely Judeo-Christian background. Furthermore, the task of clearly defining the boundaries between the ideas of religion, spirituality, and spiritual care activities is challenging due to their tight interconnection. Certain detailed information may have been obscured throughout the analysis. While we conducted extensive searches in several prominent health databases, we did not include certain databases that focus on sociological and theological studies. Lastly, findings should be regarded with caution due to the methodological and contextual differences across the studies included. These differences presented issues when analyzing, summarizing, and discussing the findings.

4.2. Practical Implications

Based on this review, the factors related to the development of spiritual care competence should be a concern, namely in PC. In this context, spirituality is paramount for all involved and plays an important role in minimizing suffering. Professionals are challenged to answer patient and family needs in spiritual care, and they are also confronted with their own spiritual needs, which should be satisfied and respected. Professionals recognize their own need for spiritual development to grow professionally and personally. Self-care and self-awareness are some of the main targets to help professionals deal effectively with the demanding needs of patients, families, and other team elements. If professionals are not comfortable with spiritual issues, they will not be able to mobilize and add the available efficient tools in spiritual care, aggravating the suffering of patients, families, and professionals.

Implementing strategies (such as structured educational and training programs) that could develop professionals' spiritual awareness, spiritual knowledge, and spiritual attitude will contribute to improving professionals' spiritual intelligence, spiritual humility, and continuous critical reflection on personal and professional spiritual experiences. This investment should be made in undergraduate and postgraduate education to improve the quality of students' performances in delivering spiritual care to patients and families, by adopting an eclectic approach that embraces diversity within society [101].

Research in this area should develop instruments that assess spiritual competence as a specific competence, a sum of knowledge, skills, attitudes, and behaviors (i.e., the cognitive, affective, and functional domains). The findings of this review indicate the need for additional

comprehensive research to evaluate the effectiveness of spiritual care interventions in enhancing the outcomes of patients, families, and clinicians.

5. Conclusions

This review aimed to identify the scope of competence and the specific skills, knowledge, and attitudes used in providing spiritual care to people needing palliative care, and the main challenges and facilitators through an evidence mapping method. Providing competent spiritual care is a right of patients and families in PC and a duty of professionals. To ensure this, all stakeholders in PC should be aware and truly involved. Patients/families should require quality spiritual care and professionals should understand the importance of developing spiritual care competence in the cognitive, affective, and functional domains.

Furthermore, PC professionals must develop and mobilize intrapersonal, interpersonal, and transpersonal resources to promote real competent spiritual care based on a person-centered approach. Promoting spiritual self-awareness and increasing spiritual maturity, through a reflective mind, are the strongest predictors of effective spiritual care. Spiritual self-awareness is achieved by engaging in life events, pursuing education, and practicing critical reflection. These activities contribute to enhancing existential and spiritual well-being, while also raising one's consciousness to a more elevated state. The process of attaining a higher level of awareness involves establishing connections with oneself and seeing patterns that enable one to develop a heightened sensitivity to the spiritual needs of others. Therefore, health managers should be aware of the impact of spiritual care investment on the health and well-being of patients and professionals. Investment in this area should be a political concern.

Supplementary Materials: Appendix A: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist and Appendix B: Summary of the included studies (n = 30).

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APPENDICES

APPENDIX A: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	Cover page
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	6
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	7-8
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	7-8
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	9
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	9-10
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	10
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	10-11
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	11-12
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	12
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	12-13
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Not applicable
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	12-13

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	12
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	11-12
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Not applicable
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	Appendix B
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	14-24
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	24-26
Limitations	20	Discuss the limitations of the scoping review process.	26-27
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	28
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	28-29

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. *PRISMA Extension for Scoping Reviews (PRISMA ScR): Checklist and Explanation*. *Ann Intern Med*. 2018; 169:467–473. doi: 10.7326/M18-0850.

APPENDIX B: Summary of the included studies (n = 30).

(Authors, year)	Title	Country	Type of Study	Objective(s)	Data Collection / Sample/ Setting	Main Findings
(American Counseling Association, 2009) [49]	Competencies for Addressing Spiritual and Religious Issues in Counseling.	USA	Guidelines	To identify competencies for Addressing Spiritual and Religious Issues in Counseling	N/A	<p>“These competencies are intended to be used in conjunction with counseling approaches that are evidence-based and align with best practices in counseling” (p.1).</p> <p>These were identified as spiritual competencies: Culture and Worldview; Counselor Self-Awareness; Human and Spiritual Development; Communication; Assessment; Diagnosis and Treatment.</p>
(Baldacchino, 2015) [36]	Spiritual Care Education of Health Care Professionals.	Malta	Review	“Present the theories and methods of clinical education on spiritual care of health care professionals and students and outline the dimensions of spiritual leadership to sustain the learning process” (p.596).	Using theoretical models and recommendations to present theories and methods of clinical education on the spiritual care of health care professionals and students.	“The essence of spiritual care is being in doing, whereby personal spirituality and therapeutic use of oneself contribute towards effective holistic care. While taking into consideration the factors that may inhibit and enhance the delivery of spiritual care, recommendations are proposed for the educational, clinical, and management sectors for further research, and personal spirituality is recommended to ameliorate patient holistic care” (p.594).
(Batstone & Hallett, 2020) [66]	Spiritual care provision to end-of-life patients: A systematic literature review.	USA	Review	“Develop an understanding of how nurses provide spiritual care to terminally ill adult patients, when spiritual need is potentially the greatest, by identifying the literature on nurses’ experiences of providing spiritual care” (p.3611).	Deductive thematic analysis. Nineteen electronic databases were systematically searched, and papers were screened (about nurses who care for end-of-life patients).	“Eleven studies provided a tripartite understanding of spiritual caregiving within the a priori themes: Nursing Spirit (a spiritual holistic ethos); the Soul of Care (the nurse–patient relationship); and the Body of Care (nurse care delivery). Ten studies involved PC nurses. Nurses who provide spiritual care operate from an integrated holistic worldview, which develops from personal spirituality, life experience, and professional practice of working with the dying. This worldview, when combined with advanced communication skills, shapes a relational way of spiritual caregiving that extends warmth, love, and acceptance, thus enabling a patient’s spiritual needs to surface and be resolved” (p.3609).
(Benito et al., 2016) [50]	El acompañamiento espiritual en cuidados paliativos.	Spain	Review	Explore synthetically what is understood by spirituality, clinical spirituality, spiritual resources, and needs, the journey of a person going through a suffering,	Using theoretical guidelines and spiritual research groups to explore and synthesize information.	Spirituality is an important dimension in PC. Spiritual healing depends partly on the maturity and experience of the healer, since no one can accompany another along their journey. Competence in spiritual care can be developed. Moments of crisis are opportunities for spiritual emergency, they create an opportunity to encounter oneself, others, and that which

(Authors, year)	Title	Country	Type of Study	Objective(s)	Data Collection / Sample/ Setting	Main Findings
				loss, or dying process, and the attitudes and tools of professionals to explore and accompany this difficult path.		transcends us, allowing us to experience what we are at our core.
(Comprehensive Cancer Centres (IKNL), 2013) [51]	Spiritual care.	Netherlands	Guidelines	Determine appropriate care and treatment (p.2).	N/A	“Pay attention to the spiritual process from the very beginning of the palliative phase” (p.4); “develop sensitivity for detecting signals on spiritual issues, as these are often not immediately apparent” (p.4); and “develop a ‘refraining mode” (p.5).
(Cone & Giske, 2022) [52]	Mental Health Staff Perspectives on Spiritual Care Competencies in Norway: A Pilot Study.	Norway	Mixed-methods study	“Evaluate use of the tool among mental health staff, and secondly describe the views on spirituality and spiritual care of healthcare personnel working in a Norwegian mental health institution and identify their knowledge, skills, and attitudes related to spirituality and spiritual care of patients in their workplace” (p.2).	Survey of healthcare personnel (n = 24) from different professional backgrounds (nurse, social educator, nurse assistants, aides) (convenience sample).	Most of the staff indicated a lack of training related to the spiritual domain. “Awareness about spiritual care and especially regarding how to develop discernment of how and when to talk with patients in ways that could be supportive, even when patients are delusional or in crisis” (p.7).
(Cooper et al., 2010) [53]	The competencies required by professional hospice PC spiritual care providers.	Canada	Case Study	“Describe a Canadian Community of Practice process to develop an occupational analysis-based competency profile for the Professional Hospice PC Spiritual Care Provider. Developing a Curriculum (DACUM) methodology” (p.869).	“Conducted a preliminary informal analysis of the status of Hospice PC concerning the spiritual care developed in Canada” (p.870).	“Competency profiles are important contributions to the development of curricula to train care providers who are recognized by other professions and by institutions as possessing the requisite theoretical and clinical expertise, particularly in academic tertiary care settings” (p.869).

(Authors, year)	Title	Country	Type of Study	Objective(s)	Data Collection / Sample/ Setting	Main Findings
(DeFoor et al., 2021) [54]	Medical student reflections: Chaplain shadowing as a model for compassionate care training.	USA	Qualitative study	“Explore perceived benefits among medical students of pastoral care shadowing in integrating compassion and spirituality into education curricula” (p.101).	Written reflections from first- and second-year medical students (n = 64) were collected and analyzed, from December 2018 to January 2020 after shadowing with hospital chaplains.	“Four major themes were identified (1) learned values within pastoral care, (2) learned roles of pastoral care in the healthcare setting, (3) practiced spiritual assessment tools and resource identification, and (4) reflected personal impact on future career” (p.101).
(Dezorzi, et al., 2019) [55]	Spirituality in the continuing education of healthcare professionals: An approach to PC.	Brazil	Quantitative study	“Evaluate the effectiveness of a continuing education activity for healthcare professionals on spirituality and spiritual care for patients/families in PC at a public hospital in southern Brazil” (p.2).	The Brazilian version of the Spiritual Care Competence Scale was applied before and after attending a four-hour continuing education activity with healthcare professionals (n = 52 in first meeting and n = 42 in second meeting).	“Significant differences were observed between pre- and post-intervention scores in the following dimensions: assessment and implementation of spiritual care; professionalization and improving the quality of spiritual care; personal support; patient counseling; and referral” (p.1).
(Elias et al, 2017) [70]	Development of a Brief Psychotherapy modality entitled RIME in a hospital setting using alchemical images.	Brazil	Qualitative study	“Analyze a training program by understanding the experience of professionals in using the RIME (relaxing, mental images, and spirituality) Intervention and understanding the experience of patients in re-signifying spiritual pain, manifested during the application of RIME by trained professionals” (p.60).	Collected 11 structured questionnaires, 21 semi-structured interviews, and 11 diaries. The sample was a nurse, a doctor, three psychologists, and a volunteer alternative therapist, all experienced or experts in PC, selected by invitation, and who cared for 11 terminal patients admitted to public hospitals in Brazil.	“In analyzing the professionals' experience, five categories and 15 subcategories were found” (p.61). In analyzing the nature of spiritual pain, the most prevalent categories were fear of death (expressed through denial) and perception of the clinical picture. When applying RIME, there was a statistically significant difference: at the end of the session, patients reported a higher level of well-being than at the beginning of the session.
(Evangelista et al., 2021) [21]	Nurses' performance in PC: spiritual care in the	Brazil	Qualitative study	“Analyze nurses' role in assisting patients in PC, with emphasis on the spiritual dimension, in the	Semi-structured interviews with nurses	“The spiritual dimension of care is contemplated by several religious and spiritual practices. These are respected and encouraged by nurses, although there is difficulty in providing care for the spiritual dimension. Nurses have

(Authors, year)	Title	Country	Type of Study	Objective(s)	Data Collection / Sample/ Setting	Main Findings
	light of Theory of Human Caring.			light of the Theory of Human Caring” (p.1).	(n = 10) assisting patients in PC.	attitudes consistent with Jean Watson’s Theory and apply the Caritas Process elements during assistance to patients’ spiritual dimension in PC” (p.1).
(Heidari et al., 2022) [26]	The correlation between spiritual care competence and spiritual health among Iranian nurses.	Iran	Quantitative study	“Investigate correlation between the spiritual health and spiritual care competence of Iranian nurses” (p.3-4).	Persian versions of the Spiritual Health Questionnaire (Amiri) and the Spiritual Care Competence Scale (SCCS). Study with Hospital Iranian nurses (n = 172).	“The study revealed that spiritual care competence of nurses is correlated with their spiritual health and performance, as a subscale of spiritual health can predict their spiritual care competence. Thus, it can be concluded that the spiritual health of nurses is an important factor in providing spiritual care for patients and meeting their spiritual needs” (p.1).
(Hull et al., 2016) [56]	Developing Spiritual Competencies in Counseling: A Guide for Supervisors.	USA	Guidelines	“Provide guidelines for counselors to implement in conjunction with evidence-based counseling practices” (p.111).	N/A	This article “describes specific supervision tools meant to develop ethical awareness and increase overall clinical competency related to addressing spirituality in counseling” (p.112). Competences: Culture and Worldview; Counselor Self-Awareness; Human and Spiritual Development; Communication; Assessment; Diagnosis and Treatment.
(Jafari & Fallahi-Khoshknab, 2021) [73]	Competence in providing spiritual care and its relationship with spiritual well-being among Iranian nurses.	Iran	Quantitative study	“Evaluate Iranian nurses’ competence in providing spiritual care and its relationship with their Spiritual Well-Being” (p. 2).	A questionnaire with the Spiritual Care Competence Scale (SCCS) and the Spiritual Well-Being Scale (SWBS) was applied to Iranian nurses (n = 158). All invited nurses were working in teaching hospitals affiliated with Bam University of Medical Sciences in the south of Iran between 2016 and 2017.	“The results showed that the mean scores of SCCS and SWBS were 101±12.6 and 76.92±13.4, respectively. Pearson correlation test showed a significant and direct relationship between the mean score of SCCS and SWBS. This test also showed a significant relationship between all the dimensions of SCCS and SWBS (p<0.05). Nurses had a relatively appropriate competence in providing spiritual care to patients. There was also a significant relationship between the nurses’ spiritual care competency and their spiritual well-being” (p.1).
(Jurado et al., 2019) [57]	A espiritualidade e a enfermagem – Uma importante dimensão do cuidar [Spirituality and	Brazil	Review	“Identify forms of spiritual interventions during nursing care and the benefits of spirituality for patients” (p.3447).	Two databases were used: <i>Literatura Latino-Americana e do Caribe em Ciências da Saúde</i> (LILA-CS) and	Despite the growing scientific production on this topic and the countless benefits of spiritual care for patients, the spiritual aspect requires greater attention from health professionals, especially nursing professionals, making it

(Authors, year)	Title	Country	Type of Study	Objective(s)	Data Collection / Sample/ Setting	Main Findings
	nursing – an important dimension of care].				Scientific Electronic Library Online (SciELO) (n = 31 articles).	necessary to qualify them to better deal with this dimension, to promote holistic and comprehensive patient care.
(Lazzaro & Lucas. 2022) [58]	Occupational Therapy's Role in Understanding the Subjectivity of Spiritual Suffering.	USA	Narrative study	"Inform occupational therapy practitioners about the concept of spiritual suffering and reaffirm a focus on spirituality" (p.151).	"Expands on the construct of spirituality as defined in the Occupational Therapy Practice Framework (4th ed.) and provides a lens for knowledge translation to assist practitioners in narrative assessment and mindful treatment regarding spiritual suffering" (p.151).	"Through an understanding of existential and postmodern philosophy, practitioners may address the lived experience of spiritual suffering that may go unnoticed due to time, knowledge, understanding, and the social-cultural factors that affect service delivery" (P.151).
(Lukovsky et al., 2021)[67]	A Survey of Hospice and PC Nurses' and Holistic Nurses' Perceptions of Spirituality and Spiritual Care.	USA	Quantitative study	"Assess hospice and palliative nurses' and holistic nurses' perceptions of spirituality and spiritual care" (p.28).	Web-based survey to measure perception of spirituality and spiritual care provision using a modified Spirituality and Spiritual Care Rating Scale with palliative nurses and holistic nurses (n = 250).	"This study found that given adequate resources and education, nurses can be positioned to address the spiritual needs of patients and provide appropriate care. This study adds to an emerging body of evidence suggesting that training in spiritual care should be an important component of the foundational nursing curriculum" (p.28).
(Mächler et al., 2023) [69]	GPs' Personal Spirituality, Their Attitude, and Spiritual Competence: A Cross-Sectional Study in German General Practices.	Germany	Quantitative study	"Understand whether there is an interrelation between spiritual competence, personal spirituality, and attitude towards enquiring about spirituality among general practitioners (GP)" (p.2436).	Spiritual Care Competence was measured using the Spiritual Care Competence Questionnaire (SCCQ) with German general practitioners (n = 30).	"Found correlations between GPs' personal spirituality, their spiritual competence, and their attitudes toward Spiritual Care (SC). The ability to perceive the spiritual needs of patients was the competence most strongly related to GPs' attitude towards SC. The competence with the strongest correlation to personal spirituality was Self-awareness and Proactive opening. The results show that GPs' personal spirituality and spiritual competence are indeed related to addressing spirituality with their patients. To foster Spiritual Care, training programs should raise awareness for one's personal spirituality and encourage one to reflect on spiritual competence" (p.2436).

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(Machul et al, 2022) [71]	The level of spiritual care competence of Polish nurses and the psychometric properties of the spiritual care competence scale (SCCS).	Poland	Quantitative study	<p>“Analyze the psychometric properties of the SCCS.</p> <p>Analyze the level of spiritual competence of professionally active nurses in Poland” (p.1).</p>	The following tools were used with Polish nurses (n = 343): Spiritual Care Competence Scale (SCCS), as developed by van Leeuwen et al.; the Duke University Religion Index (DUREL) in its Polish version; a short form collecting sociodemographic characteristics.	“The findings highlight the importance of providing professional education in spiritual nursing care, especially in its practical dimension developing skills in which nurses obtained lower scores” (p.1). Job seniority appears to be one of the main factors determining the level of competence in the provision of spiritual care.
(Miner-Williams, 2007) [59]	Connectedness in the nurse-patient relationship: a grounded theory study.	USA	Qualitative study	“Explore and describe Nurse-Patient Relationship Connectedness from the perspective of nurses and patients” (p.1216).	Fifteen people were interviewed, sharing 25 different stories of meaningful experiences from the nurse, patient, and family member perspectives.	“Findings highlighted that the nurse-patient relationship exists for the nurse to meet the health needs of the patient. Ordinarily, these are biopsychosocial needs. However, at times patients present needs emanating from deep within the person, which are deemed needs of the spirit. Under certain conditions, with a nurse who is competent and willing, a process evolves marked by meaningfulness, which not only meets these needs of the spirit but strongly impacts the nurse, the patient, or both, and promotes healing, growth, and comfort” (p.1215).
(Mthembu et al., 2015) [60]	Occupational Therapy Students' Perceptions of Spirituality in Training.	South Africa	Qualitative study	“Explore the occupational therapy students' perceptions of spirituality in training” (p.2178).	Four semi-structured interviews were conducted with students (n = 2), a lecturer (n = 1), and an occupational therapist (n = 1). In addition, two focus groups were conducted with students to collect data.	“The analysis resulted in four themes: “Unique to every individual,” “Spirituality in occupational therapy,” “To be or not to be taught,” and “The Real world.” Participants perceived spirituality as an individual experience” (p.2178).

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(Puchalski et al., 2009) [61]	Improving the Quality of Spiritual Care as a Dimension of PC: The Report of the Consensus Conference.	USA	Consensus Report (Review)	"Identify points of agreement about spirituality as it applies to healthcare and make recommendations to advance the delivery of quality spiritual care in PC" (p.885).	"Five literature-based categories of spiritual care were defined: spiritual assessment, models of care and care plans, interprofessional team training, quality improvement, and personal and professional development. The document was built upon prior literature, the "NCP Guidelines 21" and the National Quality Forum (NQF) Preferred Practices and Conference proceedings" (p.885-886). The consensus was reached by a group including 40 representative national leaders: physicians, nurses, psychologists, social workers, chaplains, clergy, other spiritual care providers, and health care administrators. A panel of 150 expert reviewers provided additional comments. All participants of the Consensus Conference and the six project advisors reviewed that Consensus Report had agreed to its content.	"Studies have indicated the strong desire of patients with serious illness and end-of-life concerns to have spirituality included in their care. There is a strong empirical and scholarly body of literature to support the inclusion of spiritual care as part of a biopsychosocial–spiritual approach to care. Recommendations were made to improve the spiritual care provision" (p.902).

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(Rivas, et al., 2022) [74]	Intervención terapéutica trascendental del profesional de enfermería al familiar acompañante en etapa de duelo.	Peru	Qualitative Study	“Describe the transcendental therapeutic intervention of nursing professionals and provide support to the accompanying family member in the bereavement stage in a public hospital” (p.2).	Semi-structured interviews via Zoom and telephone call with PC nurses (n = 10) from a public hospital.	“Three categories emerged: 1) transcendental therapeutic interventions: farewell, condolences, accompaniment, and spiritual support to the accompanying family member in the bereavement stage; 2) influence of therapeutic interventions: acceptance and posttraumatic stress reduction in the face of bereavement; and 3) need for continuous education for a more effective intervention during bereavement” (p.2).
(Rykkje et al., 2021) [62]	Educational interventions and strategies for spiritual care in nursing and healthcare students and staff: A scoping review.	Norway	Review	“Map existing evidence about educational interventions or strategies in nursing and allied healthcare concerning students’ and staff’s spiritual care provision” (p.1440).	This study of 36 sources focuses upon spiritual care competencies for healthcare students and staff, with the primary focus upon nursing, and was guided by evidence-based methods for scoping reviews, namely the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) extension for scoping reviews (PRISMA-ScR) checklist.	This review found a wide range of studies with insights into educational interventions or strategies for teaching nursing and allied healthcare students and staff about spiritual care. “The findings support the inclusion of spiritual care both in monodisciplinary and multidisciplinary educational settings, although there is no ‘right’ way or best standard to guide spiritual care curricula” (p.1440-1441).
(Seid & Abdo, 2022) [27]	Nurse’s spiritual care competence in Ethiopia: A multicenter cross-sectional study.	Ethiopia	Quantitative study	“Evaluate the current state of spiritual care competence and the factors that influence it among nurses in Southwest Ethiopia” (p.1).	The Spiritual Care Competence Scale (SCCS) was used to gather data on nurses’ competence in spiritual care, in Southwest Ethiopia (n = 367).	“The mean spiritual care competence score among healthcare professionals was 3.14±0.74. Age (p<0.05) and training in spiritual care (p<0.05) were significantly associated with spiritual care competence” (p.1).
(UK Board of	Spiritual Care Competences for	UK	Guideline	“Detail the competences required of a UK Board of	N/A	Chaplains continually develop and update their knowledge of spiritual and religious care, current policy, and evidence

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Chaplains, 2020) [63]	Healthcare Chaplains.			Healthcare Chaplains (p.2).		relevant to spiritual care services, which they use to promote and develop safe, effective, evidence-based practice.
(van Leeuwen, et al., 2008) [68]	The effectiveness of an educational program for nursing students on developing competence in the provision of spiritual care.	Netherlands	Quantitative study	“Determine the effects of a course for nursing students on developing competence in spiritual care and the factors that might influence the effects (p.2768).	Questionnaire that covered all the main nursing competencies generally expected to be present in advanced-beginner nurses in the Netherlands from Christian nursing schools (n = 97). The competences of spiritual care were measured with the Spiritual Care Competence Scale (SCCS).	“Statistically significant changes in scores on three subscales of the Spiritual Care Competence Scale between groups (T1) and over time for the whole cohort of students on all subscales (T2). Clinical placement was a negative predictor of three subscales of the SCCS. Experience in spiritual care and a holistic vision of nursing were both positive predictors of certain competencies. A statistically significant difference was observed between groups in the student analysis of a vignette with explicit spiritual content” (p.2768).
(van Meurs et al., 2022) [64]	Identifying, exploring and integrating the spiritual dimension in proactive care planning: A mixed methods evaluation of a communication training intervention for multidisciplinary PC teams.	Netherlands	Mixed-methods study	“Evaluate the effects of an interactive communication training intervention for PC teams to identify and explore the spiritual dimension and integrate them in patient care plans” (p.1493).	Self-assessment questionnaires, evaluation of videos with simulated consultations (applied competence) and medical record review (implementation). Three types of PC teams (primary and secondary): nurses (n = 21), physicians (n = 14) and spiritual caregivers (n = 3).	Training intervention resulted in increased PC professionals’ competence in identifying and exploring patients’ spiritual issues, and their integration into multidimensional proactive PC plans. “The intervention directly addresses patients’ spiritual concerns and adds value to their PC plans” (p.1483).
(Vieten et al., 2016) [65]	Competencies for psychologists in the domains of religion and spirituality.	USA	Quantitative study	“Investigate how a more general sample of psychologists respond to the spiritual and religious competencies” (p.96).	A sample of psychologists (n = 272) were asked to complete four ratings for each of the 16 proposed competencies.	Results of this survey study demonstrate a very large degree of support for the proposed competencies. More than 70% to 90% of “respondents agreed that psychologists should receive training and demonstrate competence in each of the 16 domains” (p.96). This overwhelming majority of positive responses may reflect psychologists’ increasing recognition of spirituality and religion as important aspects of human

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(Zock et al., 2017) [72]	Training hospital staff on spiritual care in PC influences patient-reported outcomes.	Netherlands	Quantitative study	"Measure the effects of a specific spiritual care training on patients' reports of their perceived care and treatment" (p.743).	Questionnaires on physical symptoms, spiritual distress, involvement, attitudes (Spiritual Attitude and Involvement List), and the perceived focus of healthcare professionals on patients' spiritual needs. The following instruments were used: Dutch translation of the Supportive and PC Indicators Tool (OPZIS); Utrecht Symptom Diary; spiritual items adapted from the Distress Thermometer; items from the Spiritual Attitude and Interests; and six items related to Spiritual Care from the report on consumer quality indicators of PC. The intervention was a specific spiritual care training implemented by healthcare chaplains to eight multidisciplinary teams in six hospitals on regular wards.	diversity, as well as their importance in people's psychological lives. "Patients (n = 85) had high scores on spiritual themes and involvement. Patients reported that attention to their spiritual needs was very important. There was a significant (p = 0.008) effect on healthcare professionals' attention to patients' spiritual and existential needs and a significant (p = 0.020) effect in favor of patients' sleep. No effect on the spiritual distress of patients or their proxies was found. The effects of spiritual care training can be measured using patient-reported outcomes and seemed to indicate a positive effect on the quality of care" (p.743).