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Spiritual Needs and Care of Patients from Nurses' Perspectives on ICU

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Abstract

Background: Current studies mainly emphasized the spiritual needs and care of cancer and hospice patients; few deal with the other critically ill patients.

Aim: This study aimed to describe the spiritual needs and care of ICU patients from nurses' perspectives.

Design: This is a qualitative study.

Method: The semi-structured guided interviewing on ICU nurses in a medical center of southern Taiwan was approved by the IRB at the research department of the hospital and data collection was carried out from January to June 2012. The investigator repeatedly read the transcribed text, and found statements relevant to the themes in the transcriptions to form significant statements as the basis of data analysis. To ensure the rigor of this study, the investigator adopted the approach of trustworthiness of qualitative research proposed by Lincoln and Guba.

Results: For the assessment of patients' spiritual needs, the patients were divided into two groups: conscious and unconscious groups. The spiritual needs of the former were assessed by the clinical observation and judgment, while the latter were assessed through family interpretation. In addition, there are six themes in general spiritual care: care skills, interaction promotion, religious belief, cultural care, wish fulfilment, alleviation of grief and terminal care. Spiritual care of the conscious and unconscious patients were also included.

Conclusion: Spiritual needs and care from ICU nurses' perspective were different from the patients; however, both of views were focused on the general spiritual care, while ICU nurses divided spiritual care into the conscious and unconscious patients.

Relevance to clinical practice: The authors suggested that a complete guideline of spiritual care for critically ill patients integrating with the cultural care and interdisciplinary cooperation could be developed on the basis of the results of this study in the future, which could provide more empirical data as the nursing reference.

Keywords: Spirituality; Patients; Intensive care nursing

Introduction

The Intensive Care Unit (ICU) is a medical-labor-intensive critical care department equipped with specialized instruments, where most of these patients undergo endo-tracheal intubation and, in addition, may be restrained physically or given sedatives or hypnotics; meanwhile, all these practices may impair patients' senses such as vision, hearing, or touch which caused difficulty in their verbal expression so that nurses were unable to understand their inner needs [1]. Although many critically ill patients cannot express their inner needs due to the diseases or treatment, it does not mean that they have no spiritual needs. However, such needs are either not recognized, or often are simply neglected. The health care team in the ICU traditionally emphasized on stabilizing patients' vital signs and relieving their physiological symptoms, but rarely paying attention on the patients' psychological and spiritual needs [1].

Meanwhile, [2] conducted a content analysis of 15 adult ICU from United States and Canada to identify the forms of documentation and results shown spiritual support as not well-prepared. Continuously, most of studies on spiritual care needs were focused on the general, cancer, and hospice patients and the studies on the spiritual needs of patients with critical illnesses were greatly scarce. Again, Rodriguez et al. [3] reported that only 16% of 31 ICU nurses would provide the end of life spiritual care commonly. Simiarly, Turan and Karamanog lu [4] survey 123 ICU nurses from four Turkey hospitals about their perceptions and practice levels of spiritual care and identified that inappropriate spiritual care practices were found.

Purpose of the Study

The study aimed to describe the spiritual needs and care of ICU patients from nurses' perspectives.

Literature Review

In terms of spiritual needs, Timmins and Kelly [5] overviewed the spiritual assessment for ICU/CCU nurses and suggested that nurses in such units better selected the assessment tools as fit into the definition of spirituality as well as the mission statement and philosophy of care

based on the patients' point of view. Chao et al. [6] used hermeneutic study to explore the essence of spirituality among terminally ill patients by in-depth interviews with six terminal cancer patients in the hospice ward of a teaching hospital. The results comprised four patterns as communion with self, others, nature, and a higher being. Additionally, Papathanassoglou et al. [7] explored the experiences of 8 critical patients who have lived in the ICU by using phenomenology and identified three themes as transformation, transcendence, and rebirth as well as critical illness being conceptualized as a cocooning phase to transform self, promote spirituality, and personal growth. Continuously, Murray et al. [8] explored the spiritual needs of dying patients by in-depth qualitative interviews with 20 patients with lung cancer and 20 patients with terminal heart failure. Whether or not the patients held religious beliefs, they expressed the need for love, meaning, purpose and transcendence.

In terms of spiritual care, Hsu [9] divided the intervention strategies for satisfying the spiritual needs of terminal patients into two categories: general spiritual care and special spiritual care. The general spiritual care included palliative care, group psychotherapy, supportive treatment, depth psychotherapy, practice guided therapy, and treatment for demoralization. The special spiritual care included alternative therapy, such as therapeutic touch, acupuncture, biofeedback, relaxation techniques and aromatherapy, psychotherapy with deity, logo-therapy and dignity therapy. Furthermore, Lin et al. [10] proposed spiritual nursing interventions in the aspect of "communion with self", therapies such as life review or reminiscence, supported by logo-therapy, in particular when the patients felt that life had lost its meaning and value under the threat of death. In addition, the patients could be assisted to accomplish their wishes. In the aspect of "communion with others", nurses could play the role of a bridge to help the patients to maintain and reconstruct relationships with others. In the aspect of "communion with nature", nurses could teach the patients to achieve spiritual relaxation through aromatherapy, music therapy or imagery therapy, or to understand their inner feelings through painting or writing. When the patients felt frightened or anxious, playing the patient's favorite soft music could help to ease their perturbed emotions. In the aspect of "communion with a higher being", nurses could introduce religious beliefs to the patient as own needed, and arrange for priests or religious leaders to hold special religious rituals such as praying, chanting, worshiping, etc., with the aim of establishing communication between the patients and the higher being of their beliefs.

Currently, Lundberg and Kerdonfag [11] interviewed 30 Thai nurses from 6 different ICUs with the aim of exploring how they provided spiritual care to the patients in the qualitative study. The study found five themes related to the provision of spiritual care by nurses: giving mental support, facilitating religious rituals and cultural beliefs, communicating with patients and their families, assessing the spiritual needs of patients, and showing respect and facilitating family participation in spiritual care. Continuously, Zeilani and Seymour [12] used narrative approach to explore the 16 Muslim women's experiences of suffering in ICU and they interpreted suffering with physical, social, spiritual, and technological themes, including pain, unfamiliar environment, feeling uncertainty. However, religious beliefs and cultural norms as well as social supports were identified as the essential variables for them to adjust the suffering.

Method

This study used a qualitative approach to describe the nature, meaning and values of phenomena in specific life experiences [13]. Samples were ICU nurses in a medical center of southern Taiwan selecting by purposive sampling with the criteria as follows: (1) had worked in a medical ICU for at least two years, (2) were interested in spiritual care or had such care experiences and (3) had taken at least two hours of courses on spiritual care. The numbers of interview samples for this study were closed when the data approaching saturation during analysis. The proposal of this study was approved by the Institutional Review Board (No.100- 3745C) at the research department of the hospital before data collection. Data collection of this study was conducted for 6 months from January to June 2012. An interview guide was developed based on the study objective, literature validation, and personal clinical experiences of the principal investigator, and was revised once after the first pilot test. The place to conduct the interview was decided by the participants either at their homes or workplaces with one-to-one face in the natural surroundings without disturbance. Each interview took about 40 to 60 min. After each interview, all data were transcribed into an original, true and complete verbatim context, and conducted data analysis one case following the other until data saturation.

As for ethical consideration, the principal investigator followed the principles of interests, dignity and justice [14] for the benefit of participating ICU nurses. Conforming to the principle of interests, this study had assured no physical harm to any nurses, no criticism of their thoughts and conduct, and no overstimulation of their emotions. To express the appreciation for sharing their precious experiences, the principal investigator gave a small present when the nurses agreed to participate in this study. Conforming to the principle of dignity, the principal investigator did not threaten, bribe, or coerce the nurses to participate in this study with the superior authority in the hospital. The participants were fully informed about the objective of the study, the procedure, and were required to agree to audio record their interview with a written consent prior to the study. However, samples who wished to stop the recorded interview or terminate their participation could do so at any time. Conforming to the principle of justice, confidentiality and anonymity would be maintained, nurses' names would not appear in the documents, but replace them with the numbers, so that the individual identities would not be revealed or implied, and finally an integral presentation would be given in the study results.

The investigator was the main instrument of this study, which owned an RN license with working in an ICU at a medical center for 15 years, and had, took a two-credit course on qualitative research for 36 h during studying in the graduate school of nursing in an university. In this study, data analysis and collection were simultaneously conducted. First, the principal investigator cast aside previous views on ICU nurses, adopted an open attitude, and repeatedly read the transcribed text, tried to understand the context and the integral concept, and then found statements relevant to the research themes in interview transcriptions to form significant statements as the basis of data analysis. Moreover, the investigator sought to deepen the understanding of ICU nurses' experiences and employed descriptive analysis to extract meaning from significant statements, grouped common features of significant statements into themes, gave an exhaustive description of grouped themes and expounded on the essential structure of the phenomena. During the interviews, the

statements of informants were reviewed once again by each informant to ensure that the contents reflected their empirical experiences.

To ensure the rigor of this study, the principal investigator adopted the approach of trustworthiness of qualitative research proposed by Lincoln and Guba [15] which involves establishing credibility, confirmability, dependability and transferability. First, to maintain the credibility of data, the principal investigator held neutral, open, and impartial attitudes to the feelings and thoughts of informants while interpreting their experiences. Second, for the confirmability, the principal investigator asked typical participants to read, review and discuss analyzed themes and transcriptions during the whole process of analysis to ensure that the results reflected the real experiences of participants. For dependability, the principal investigator cooperated with an expert, who had taught the spiritual nursing course and engaged in qualitative and quantitative research on spirituality for more than 10 years with publishing many relevant articles, reports and case studies about spiritual care in Taiwan and abroad, to review and ensure the consistency of data analysis. For transferability, the principal investigator used purposive sampling referred as much as possible to informants' rich clinical experiences of spiritual care in the data analysis of interviews, which could be transferred to the clinical practices of other ICU nurses.

Results

These 11 participants are all single, female, university graduates, with an average age of 35 years old, and mostly Taoists. Their average nursing experience and ICU experience were 15 and 12 years, respectively. Following are the axis and perspectives for the nurses' assessment of patients' spiritual needs and nurses' providing of patients' spiritual care for conscious and unconscious patients.

Nurses' assessment of patients' spiritual needs

The axis of assessment of patients' spiritual needs contained two perspectives: Conscious patients and unconscious patients.

Conscious patients

The perspective of conscious patients was clinical observation and judgment.

Clinical observation and jugement

In clinical situations, while nurses could directly ask conscious patients about their spiritual needs, the responses might come as verbal and non-verbal behaviors. For example:

"With conscious patients, we could understand their thoughts. Some patients may know they are going to leave the world. They seem to be able to foretell the end is near (crooking the index finger, which means to die). Generally, we would tell him/her not to dwell upon unnecessary issues. We would observe what they need and immediately provide help. If they could write, we will let them write. If not, they could let us know the needs by gestures. If the patient used to pray or listen to something at home, we would let him continue to do so." (Case 1)

Unconscious patients

The perspective of unconscious patients was family interpretation.

Family interpretation

As many ICU patients were unconscious, nurses should have greater sensitivity and pay more attention on the family. For example:

"The family decided all. When the patient needed some support, what he/she needed is to be accompanied by the family. Some families might think everything was unnecessary, like pictures were unnecessary, etc. No! No! Nothing is necessary! (In Taiwanese) Some families might decide everything for the patient because the intubation patients could not speak, express, and showed no reactions. The family was the big influencing the mind of the patient. Success or failure depended on the family. For the patients, the most important connection was from the family, not us. But when the family dismissed patients' feelings, their spirituality would be shut off with a closed door and simply ignored. (Case 8)

Nurses' providing of patients' spiritual care

The axis of spiritual care by nurses contains three perspectives: General spiritual care, spiritual care for conscious and unconscious patients.

General spiritual care

The perspective of general spiritual care includes six themes: care skills, interaction promotion, religious belief, cultural care, wish fulfilment, alleviation of grief and terminal care.

Care skills

In clinical spiritual care, nurses should patiently take time to understand patients' needs, establish good relationships with patients, and provide as the bridge of communication between the patients and their families. For example:

"We tell jokes to patients to divert their attention. It depends on patients; some like to be Sometimes we may chat or tell jokes while the nurse is treating the patient. In such a way, the patient may divert his/her attention and the time may appear to pass faster. The patient may feel different and better if we sometimes tell jokes or talk about our families. In that way, we treat the patient as a family member and he/she wouldn't feel like a patient." (Case 3)

Interaction promotion

When critically ill patients are admitted into the ICU, nurses can timely provide patients with companionship and concern of familiar persons, allow them to keep habitual, familiar or meaningful articles at bedside or somewhere they can see, ask the family to tape record words of encouragement, play the tapes of the patient, his/her family or some familiar people's voices or singing, and guide the family to interact and communicate with patients. For example:

"We guide the family to interact more with the patient. How to guide depends on the condition. When the family sees so many tubes in the patient, they may get scared, not knowing which part of the patient they can or cannot touch. Usually we would instruct the family to give the patient a massage and help exercise the muscles and joints of the patient's limbs. Above all, patients desire their families. They need their families. When they are nervous and scared, they require the company of a familiar person, a family member. Yes! They hope to be accompanied by their family. We guide the family to talk with the patient, to bring family photos or tapes for the patient and sometimes

ask the family to record tapes with words of encouragement. The family does it, too. We let the family accompany the patient as much as possible, when it's necessary. It is very meaningful and helpful to a patient's spirit when many people come to see and care for him/her. When you are sick, you feel particularly vulnerable and you wish for more attention and care. In that way, you won't feel abandoned." (Case 3)

Religious belief

Nurses can provide spiritual care in the following ways: allowing patients to listen to Buddhist sutras, Amitabha, religious music or hymns via a player and to recite along, allowing patients to wear Buddhist prayer beads or Buddha figure pendants and placing Buddhist sutras, the Bible or crosses on their clothes, below the pillow, at the bedside or somewhere that the patient can see, which should be noted down on the shift checklist; placing god figures or pictures; providing worship halls, asking Protestant ministers or Catholic priests to lead the worship in the ward, pray or sing hymns with the patient; asking the religious workers to accompany and talk to the patient. For example:

"Patients may say they want to recite Amitabha with a Buddhist sutra player or to read something. We offer it accordingly and assist as much as we can, but only if their conditions permit. It would be better if the religion can give patients support. They may need articles such as Buddhist sutras, prayer beads, Buddha figures, etc. Some may wear Buddha figure pendants, pictures of Jesus, Bodhisattva or Mazu, or place them at their bedside. These are not expensive articles, such as Buddhist prayer beads that the patient used to pray with, or a god figure or a picture of Guanyin put on the patient or posted on the ward bed." (Case 1)

"For Protestants or Catholics, a crowd may come to the ward for worshipping or praying, not simply to visit. It is better for the patient and, I think, the effect is more obvious. The patient sees people praying for him/her. In particular, it makes more difference if the priest also comes for him/her. All people come to pray for him/her, making him/her feel like a god. After the worship, he/she would feel more hopeful about his/her condition. If you just put a god figure and tell the patient "God bless you", his/her feelings may not be as strong! I think, other people's praying would be more powerful. Only placing some charms on the patient's body cannot have such effects. Christians are quite united; they may come to the hospital particularly on Sunday to pray for the patient; even the priest comes quite often. For the patient, seeing the priest is like seeing the light! Wow! he/she becomes hopeful and uplifted. The patient feels honored." (Case 4)

Cultural care

Spiritual care is often influenced by personal beliefs and social culture, and nurses should have insights into different cultural backgrounds and customs of the patients for providing the sensitive cultural care. Clinically, we often find that the family may make the patient wear a necklace, amulet, or incense bag blessed by the temple or a diviner, take the patient's clothes to the temple for passing-over-fire ritual, feed the patient worshiped incense ash, place a round container like an incense burner with turtle eggs or stones inside, set Taoist Wang Ye flags by the bed headboard, make the patient wear divine clothes, Wang Ye's headband or a whole yellow top, i.e., yellow cloth for the dead, spray sacred water on the patient's body and all around the ward or dab the patient's lips with the water, or place leaves by the pillow of the patient to drive off evil spirits. For examples:

"A necklace! They would wear a necklace sought from the temple! It is frequent that the family goes to seek divine advice. Once the patient is admitted to the ICU, the family would not only look for medical assistance, but also seek folk treatment or divine advice. The family may bring back many incense bags or clothes with red temple stamps, which are believed to remove bad luck. Taking the patient's clothes to the temple for passing-over-fire ritual is also for the same purpose, to remove all the bad luck and to ensure safety. The clothes are put on the patient, cover the patient, or put by the pillow, as the family particularly requests. We would help to put them by the pillow or on the patient. When the family comes, they would change the clothes themselves." (Case 1)

"They may bring some incense bags for ensuring the patient's safety. I have even seen the family put leaves on the patient or by the pillow, saying that it could drive off evil spirits. The family may also spray sacred water on the patient and all around the ward or dab the patient's lips with it." (Case 2)

"They may tell the patient, "The incense bag will bless your safety. Gods are taking care of you (In Taiwanese)." They would say some words to put the patient at ease and the patient might think, "You see! My family also heads to the temple to pray for me." Some families have sought sacred water or incense bags for the patient. We let the family put them on the patient. Some also have wanted to feed the patient incense ash given by gods for blessing their safety. We respect that and do not intervene. I tell them to do it themselves if they have such needs because I respect the patient. When the patient or the family hopes to place the incense bag by the head, on the body or near an organ of the patient, we give them all our respect." (Case 7)

"Some want to place a round container like an incense burner with turtle eggs, stones, charms or divine clothes inside. They may ask if it is allowed to set Taoist Wang Ye flags by the bed headboard, some in small size and some large ones. The divine clothes will cover the patient. It could be a short Wang Ye headband or a yellow top. Moreover, terminal patients may want to be covered with a large piece of yellow cloth for the dead." (Case 10)

Wish fulfillment

Nurses can help the patient to fulfil wishes. For example:

"Some patients knew that they would soon leave the world. They might foretell the end of life. You can ask the patient if he/she wants to see any person, to see a son or daughter who lives at a distant place or abroad and then help him/her to ask his/her family to come back. Or, you can ask if he/she has any wish or wants to do something special and then help him/her to fulfill it. Recently, we took care of a very young patient. He was unconscious when he was admitted into the ICU. His consciousness returned after the treatment, but he became very agitated. It was through his handwriting that we learned he wanted to see his wife, son and daughter." (Case 1)

Alleviation of Grief and Terminal Care

Nurses should help the family to alleviate their grief and pay attention to the mental status of the family. The care should cater not only to the patient, but also to the family. With empathy, nurses can give the family a buffer period. For example:

"No one suggested doing this, but I felt I should do it. All of a sudden, her condition deteriorated and her cancer spread all over her body. I discussed it with her husband. They wanted to follow the patient's wish; it would be better not to insert her trachea tube. At that time, her child was about four, the age of innocence. So we thought to encourage the child not to fear and ask the child to accompany the mother until she took her journey to heaven. Then the patient passed away. But at least, I think, the patient passed away very peacefully and serenely. We helped her to clean up and comb her hair while the child stayed close by. At least, I think, no shadow of fear would be left in the child's mind. This was an impressive case. The family was grateful that we let them hold her hands and accompany her when she passed away, instead of letting her leave the world alone." (Case 4)

Perspective of spiritual care for conscious patients

Nurses' spiritual care for conscious patients should contain the following interventions: listening, comforting, encouraging and accompanying the patient, communicating with the patient face-to-face, talking with the patient about his/her needs, trying to understand what he/she thinks, fulfilling the wishes of the patient, letting the patient listen to religious scriptures, offering newspapers or magazines to the patient, helping the patient to find the physician or nurses that he/she has trusted, letting the patient read or watch TV, letting the family accompany the patient when the patient has the need and satisfying the patient's needs, assisting with the communication between the family and the patient,. For example:

"He might want to look for the doctor whom he/she trusted before, or he/she wants to find some nurse. Or he/she said he/she wanted to listen to Buddhist sutras, or read the Bible. He/she wanted to read a book or watch TV. Normally, those with clear consciousness feel bored in the ICU and their only desire is to leave the hospital soon and go home. We would try to comfort him/her, telling him/her to wait patiently for the meeting hours since the family is not allowed to enter the ICU now. If it's truly necessary, we can still timely help him/her to arrange for the family to visit and keep him/her company, which will make the patient feel safe and at ease. Then we tell the patient that his/her family is waiting in the lounge and won't leave, so they can be found anytime. Or, we tell him/her that it is hard for his/her family to take turns caring for him/her and that it would be better to let the family go home for a rest and come back to visit him/her later. Many patients can accept it!" (Case 7)

Perspective of spiritual care for unconscious patients

As for nurses' spiritual care for unconscious patients, since nurses cannot understand the thoughts of the patient, nursing care puts greater emphasis on the family: Encouraging the family to have physical contact with the patient or to speak with the patient, letting the patient hear the voice of the family, letting the family accompany the patient or prolonging visiting hours if necessary, letting the patient listen to the tapes with the recorded voice of the family, being accompanied by a radio, guiding the family to let the patient go at the end of his/her life. This is the moment when the family usually needs more care and communication than does the patient; nurses should have greater sensitivity and ask for the intervention of a palliative care coordinator or social worker if necessary. For example:

"For patients without clear consciousness, more attention should be paid to the family. Some care very much for the patient and cannot let the patient go at the end of life. We all know that the time is almost over, but the family just cannot accept it. Then we have to tell the family that the patient has suffered for a while and it might be better to let the patient go since he/she is in such a poor state of health. Tell the family to let go and that everyone has done his/her utmost." (Case 1)

"For unconscious patients, we would suggest for the family to give the patient a body massage and to help move and stretch the patient's limbs. The family can continue to speak to the patient, letting the patient hear the voices of the family. We can't do too many things to the patient, because he/she may already be in a coma when we intervene. So the focus would be on the family. After all, ICU patients are mostly in the worst health conditions; they may be unconscious, in a coma or slowly recovering from unconsciousness after a period of treatment." (Case 3)

Discussion

By using a qualitative approach, this study described the experiences of ICU nurses on the spiritual care for critically ill patients, including nurses' assessment of patients' needs and spiritual care by nurses. Based on our data analysis and literature review, the authors offer the following discussion.

Nurses' assessment of patients' spiritual needs

Although Timmins and Kelly [5] suggested ICU nurses choosing the assessment tools of spiritual care based on the patients' point of view, the results showed that two perspectives in the assessment of patients' spiritual needs: conscious and unconscious patients, including two themes: clinical observation and judgment, and family interpretation, were all from the nurses' point of view. However, the current literature explored conscious patients' spiritual needs from both the perspectives of patients and nurses, but appeared to know little about unconscious patients' spiritual needs from the nurses' point of view as the findings in this study. Additionally, four patterns of communion with self, others, nature, and a higher being as well as three themes of transformation, transcendence, and rebirth with the need for love, meaning, purpose were considered as the core essences of spiritual needs for the critical patients [6-8].

Nurses' providing of patients' spiritual care

The results of this study showed that the 11 ICU nurses divided their spiritual care according to general spiritual care, and spiritual care for conscious and unconscious patients, which was different from Hsu [9] divided the spiritual intervention strategies into general and special spiritual care. The previous study was based on the patients' point of view, rather than this study was focused on the nurses' point of view. Specifically, comparing the previous studies on non-ICU units with the present study, the following aspects of spiritual care by non-ICU and ICU nurses were majorly on general six themes, including care skills, interaction promotion, religious belief, cultural care, wish fulfilment, alleviation of grief and terminal care. For instance, the aspects of spiritual care by ICU nurses included psychological, cultural, and religious perspectives of care through assessment and communication with the patients and their family members in the respectful attitudes [10], which were all similar to the themes underlined in the general spiritual care of this study. Additionally, Zeilani and Seymour [12] suggested the religious beliefs, cultural norms, and social supports as the essential components for ICU patients to adjust their suffering, which were also comparable to the themes underlined in the general spiritual care of this study. Nevertheless, the results of this study

showed that spiritual care for conscious and unconscious patients were different from Lin et al. [10] proposed spiritual nursing interventions in the aspect of communion with self, others, nature, and a higher being.

Conclusion and Suggestions for Future Studies

Using a qualitative method, this study described the ICU nurses' experiences of spiritual care for critically ill patients. For the assessment of patients' spiritual needs, the patients were divided into two groups: conscious and unconscious groups. The spiritual needs of the former were assessed by means of clinical observation and judgment, while the needs of the latter were assessed through family interpretation. In addition, the spiritual care by nurses includes general spiritual care, as well as spiritual care for conscious and unconscious patients. Six themes in general spiritual care included care skills, interaction promotion, religious belief, cultural care, wish fulfillment, alleviation of grief and terminal care. Furthermore, spiritual care of the conscious and unconscious patients were also included.

In conclusion, spiritual needs and care from ICU nurses' perspective were different from the patients; however, both of views were focused on the general spiritual care, while ICU nurses divided spiritual care into the conscious and unconscious patients. The spiritual needs and care of the former were focused on the patients' point of view, whereas the needs and care of the latter were assisted through family interpretation. Additionally, among the guidelines of spiritual care, none is available for critically ill patients. Since this study found that the spiritual needs and care of critically ill patients who were highly culturally influenced, Penrod et al. [16] conducted an integrated palliative nursing care into ICU as quality improved program and suggested to apply the interdisciplinary training for ICU health professionals as well as Hughes et al. [17] integrated Chaplain to 12 ICU units with the cooperation of critical care and palliative nurses for spiritual care assessments. The cultural bound spiritual care in Taiwan was deeply involved into the Taoist religion, including wearing the divine cloth and a yellow headband, as well as eating of ash that all symbolized the way of protection the critical ill patients from getting evil spirits and could recover soon. Therefore, the authors suggested that a complete guideline of spiritual care for critically ill patients integrating with the cultural care and interdisciplinary cooperation could be developed on the basis of the results of this study in the future, which could provide more empirical data as the significant nursing reference.

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