

2020

Responding to the "unknown assailant": A qualitative exploration with Australian health and aged care chaplains on the impact of COVID-19

Kate Fiona Jones

The University of Notre Dame Australia, kate.jones1@nd.edu.au

Jennifer Washington

Matthew Kearney

Megan C. Best

The University of Notre Dame Australia, megan.best@nd.edu.au

Follow this and additional works at: https://researchonline.nd.edu.au/ies_article



Part of the [Religion Commons](#)

This article was originally published as:

Jones, K. F., Washington, J., Kearney, M., & Best, M. C. (2020). Responding to the "unknown assailant": A qualitative exploration with Australian health and aged care chaplains on the impact of COVID-19. *Journal of Health Care Chaplaincy, Early View (Online First)*.

Original article available here:

[10.1080/08854726.2020.1861536](https://doi.org/10.1080/08854726.2020.1861536)

This article is posted on ResearchOnline@ND at
https://researchonline.nd.edu.au/ies_article/9. For more
information, please contact researchonline@nd.edu.au.



©2020. This manuscript version is made available under the CC-BY-NC-ND 4.0 International license <http://creativecommons.org/licenses/by-nc-nd/4.0/>

This is an Author's Original Manuscript of an article published by Taylor & Francis Group in the *Journal of Health Care Chaplaincy* on 28 December 2020, available online:

<https://www.tandfonline.com/doi/full/10.1080/08854726.2020.1861536>

Jones, K.F., Washington, J., Kearney, M., & Best, M.C. (2020). Responding to the “unknown assailant”: A qualitative exploration with Australian health and aged care chaplains on the impact of COVID-19. *Journal of Health Care Chaplaincy, Online First*.

<https://doi.org/10.1080/08854726.2020.1861536>

Responding to the “unknown assailant”: A qualitative exploration with Australian health and aged care chaplains on the impact of COVID-19

Authors

Kate Fiona Jones^{1,2}

Jennifer Washington²

Matthew Kearney²

Megan C Best¹ Orcid ID: 0000-0003-1570-8872

Affiliations

¹ Institute for Ethics and Society, University of Notre Dame Australia

² St Vincent’s Hospital, Sydney, Australia

Corresponding Author

Dr Kate Jones

Orcid ID: 0000-0002-5964-3479

Institute for Ethics and Society, University of Notre Dame

PO Box 944, Broadway NSW 2007, Australia

Ph: +61 414 875 163, E-mail: kate.jones1@nd.edu.au

Responding to the “unknown assailant”: A qualitative exploration with Australian health and aged care chaplains on the impact of COVID-19

Abstract

The global coronavirus pandemic (COVID-19) has brought about physical, psychological and spiritual challenges within health and aged care services across Australia. The aim of this study was to consider the impact of COVID-19 from the perspective of Australian chaplains. Semi-structured interviews were conducted with 17 chaplains. A grounded theory analysis identified three overarching themes: (1) a changing healthcare environment; (2) the impact of the virus; and (3) chaplains responding to the crisis. Increased healthcare restrictions in response to COVID-19 raised levels of fear and anxiety among patients, residents, family members and staff, and generated feelings of isolation and disconnection. Chaplains responded by providing a calm presence, being available and holding out hope, introducing creative ways to provide spiritual care and seeking spiritual nourishment themselves. The value of chaplaincy in health and aged care services is discussed in light of these findings.

Keywords: chaplaincy, COVID-19, hospital care, aged care, pandemic

Introduction

The COVID-19 (novel severe acute respiratory syndrome coronavirus 2 – SARS - CoV2) pandemic has had a far-reaching global impact (World Health Organisation, 2020). High morbidity and mortality rates, associated physical and social restrictions, and increasing economic uncertainty, have had a substantial effect upon psychological well-being for individuals, families and communities (Brunier & Drysdale, 2020; Newby, 2020). Some of the known psychological impacts of the pandemic include stress, anxiety, depressive symptoms, insomnia, denial, anger and fear (Torales, O’Higgins, Castaldelli-Maia, & Ventriglio, 2020). High death rates have led to fear, anxiety and self-isolation for many, generating a crisis of spiritual distress (Ferrell, Handzo, Picchi, Puchalski, & Rosa, 2020).

At the time of writing, global cases of COVID-19 continue to rise exponentially (World Health Organisation, 2020). According to the World Health Organisation (WHO) the death toll world-wide currently stands at over 1 400 000. Once the contagious and deadly nature of COVID-19 became known in Australia, restrictions were brought in rapidly. Policies implemented by health and aged care services were instituted prior to the first wave and in response to the pandemic’s impact in Europe (Borrello, 2020). In some cases these were introduced by government health authorities (Morton, 2020), in other cases, by individual healthcare providers (Mayers, 2020).

In Australia, the mortality rate associated with COVID-19 has to date been relatively low (Woodley, 2020). Some states in Australia have seen very few or no deaths. By May 2020 only 100 deaths had been recorded (ABC News, 2020). In June 2020 a second wave of the virus emerged in the state of Victoria (Briggs, 2020) raising the death toll to 905 by the end of October 2020. Border closures, physical distancing guidelines, and local restrictions

on business and commerce have had a significant impact upon economic, social and psychological well-being (O'Sullivan, Rahamathulla, & Pawar, 2020).

Australian health and aged care facilities are staffed by a range of health professionals, and can include doctors, nurses, and members of allied health (e.g. physiotherapists, occupational therapists, speech pathologists, social workers, psychologists). Chaplains, also known as spiritual care practitioners or pastoral care providers, provide spiritual care to patients, family members and staff at many Australian hospitals and aged care facilities (Best, Washington, Condello, & Kearney, 2020; Holmes, 2018). Chaplains employed by health and aged care services may be included as part of the multi-disciplinary team or employed as separate entities affiliated with religious or faith associations. A recent study (Best et al., 2020) identified key components of the pastoral care role among hospital chaplains in Australia. These included: whole person care, assisting patients to make meaning of their experience, providing psychospiritual care, building relationships, supporting staff and families as well as patients, and providing education about the purpose of pastoral care. Challenges encountered by chaplains included knowing how to promote pastoral care to the wider healthcare team, the hidden nature of the work, and misunderstanding of other healthcare professionals regarding the nature of pastoral care.

Research into the role of chaplaincy during the COVID-19 pandemic is growing (Drummond & Carey, 2020; Harrison & Scarle, 2020; Swift, 2020). In an Australian case study, Drummond and Carey (2020) demonstrated that COVID-19 had an impact physically, psychologically, socially, and spiritually for those living in an aged care setting. In the United Kingdom, Swift (2020) has explored the challenges of chaplains restricted to working virtually due to the pandemic, rather than in-person. Few studies have investigated the impact of a global pandemic across a nation by using qualitative methods. Through such qualitative

exploration, the aim of this study was to consider the impact of COVID-19 from the perspective of Australian health and aged care chaplains.

Methods

Ethical approval was obtained from the University of Notre Dame Australia Human Research Ethics Committee (2020-061S). A letter of invitation to participate in the study was sent out to the membership of Spiritual Care Australia, a national professional association of practitioners in chaplaincy, pastoral care and spiritual care. Inclusion criteria included being a chaplain who worked within a health or aged care setting. Written consent was obtained electronically, and demographic details were obtained for each participant through completion of an online survey before a time for an interview was arranged.

Semi-structured interviews (Minichiello, Aroni, & Hays, 2008) were conducted by the first author with Zoom video conferencing software and were held between May and September 2020. Interview questions are provided in Appendix 1. The duration of interviews was between 30 and 45 minutes. All interviews were recorded, and transcribed verbatim by a professional service.

Data analysis

A grounded theory analysis approach was used (Charmaz, 2006) to analyse the data. Data was independently coded by three researchers. These preliminary codes were then used to synthesize groups of data into focused codes which were applied to further transcripts to establish agreement on coding and refine the code tree, which was then applied to the remaining transcripts. Using the constant comparative method, new codes were written as required and new theory generated. Through iterative reading of data grouped by focused codes, axial codes were established and the relationships between them studied to build theory. Theoretical sampling allowed exploration of each code until they were well

understood and theoretical saturation was achieved. Rigor was derived from successive rounds of discussion and development of focused codes, definitions and themes and review of the coding process by all authors until theoretical coding was complete. The different disciplinary backgrounds (social work, palliative care and pastoral care) brought to these discussions allowed for reflexivity.

Results

A total of 17 chaplains were interviewed. All participants worked in a health or aged care setting. Of the six states and two territories in Australia, five were represented in this study (New South Wales, Victoria, Tasmania, South Australia, Queensland). The majority of chaplains identified their religious affiliation to be Christian. Demographic details are provided in Table 1.

Insert Table 1 here

Three overarching themes were identified in the analysis with associated sub-themes: (1) a changing healthcare environment; (2) the impact of the virus; and (3) chaplains responding to the crisis.

Themes

1) A changing healthcare environment

Policy change in response to COVID-19 varied between states, institutions, and over time. Three key changes identified by participants were: i) changes to visitor access; ii) a reduction in vulnerable or non-essential staff; and iii) restrictions regarding face-to-face contact with patients.

i) Changes to visitor access

Visitor restrictions were introduced at all the facilities described, however the nature of these restrictions varied from facility to facility, and ward to ward. One participant stated that no visitors were allowed at all in the hospital where they worked. Others referred to policies where only one nominated visitor per patient was allowed. Most participants spoke about exemptions being made in special circumstances such as palliative care. In the majority of cases, children under the age of 12 were not allowed to visit.

Visitor restrictions impacted all patients and residents in health or aged care facilities, not just those personally affected by COVID-19. A participant at one hospital where no visitors were allowed, described how one distressed couple told staff “*we haven’t been apart for 50 years*” (Participant 1). Even those with catastrophic injuries or illnesses were not allowed visitors, including a woman who had recently been diagnosed with brain cancer.

ii) Reduction in vulnerable or non-essential staff

Most hospital and aged care facilities brought in measures to protect vulnerable staff from contracting COVID-19, such as by removing non-essential staff. This had a large impact upon the involvement of volunteers. One participant explained “*If we were over 65 with any comorbidities, or over 70, everyone had to stay home...we needed to do only what was necessary, was the message*” (Participant 14). In some circumstances, all volunteers were stood down. This change led to reduced support for patients and residents, and simultaneously increased the workload for paid staff. One participant described how “*all our volunteers were locked out of the hospital. So people that would normally be available to help out just being a social presence on the ward, they’re all gone as well. So, they’re all things that the nurse at the bedside has had to try and cover*” (Participant 3). Various roles of volunteers were highlighted by participants and included faith-based support from clergy,

activity co-ordination at aged care facilities, visiting sick children in a pediatric hospital, and giving massage to patients in palliative care.

iii) Restrictions regarding face-to-face contact with patients

In some hospitals, new restrictions were placed on how often staff physically interacted with patients. Physical touch was not allowed for most members of the multidisciplinary team, unless it was deemed to be essential “*clinical touch*”. Several participants described how they could no longer make unscheduled “cold call” visits to new patients. For these chaplains, all patient contact was by referral only. However, in some facilities ward visiting could continue, albeit with stringent hygiene practices in place. Later in the pandemic new policies were introduced when there was a greater incidence of community transmission. For some this involved the use of masks and daily temperature checks for all staff.

These restrictions led to the increased use of electronic devices in the healthcare setting. Participants highlighted some drawbacks of using such devices. For instance, one participant remarked “*how do you manage family all around a videoconference with somebody who’s dying and who can’t pick up a device?*” (Participant 4). A chaplain working with community palliative care patients described her experience of phone consultations:

...it’s actually a lot harder doing phone interviews because you don’t have those prompts and so if somebody is silent, you don’t know if it’s because they’re crying or if they’re distracted, or if they’ve fallen asleep (Participant 22).

In a few of the facilities where participants worked, staff were encouraged to continue face-to-face contact with patients as usual. This did not usually extend to COVID-19 wards, which were separated from the rest of the hospital.

2) *The impact of the virus*

The COVID-19 pandemic had a significant impact upon staff, hospital patients, aged care residents and family members. Three subthemes were: i) fear of the “unknown assailant”; ii) isolation and disconnection; and iii) fear of transmitting the virus.

i) Fear of the “unknown assailant”

The media reports of COVID-19 outbreaks overseas were unsettling for all participants, and for some overwhelming. One participant commented *“you talk to people in the corridor and you’d overhear conversations and people would be saying ‘Well, we’re just waiting for the tsunami to hit’”* (Participant 28). Another participant commented: *“But I just had to stop watching the television and turn off Facebook because it was too much. It was making me feel so anxious”* (Participant 14). One explained *“people were frightened of an unknown assailant that could impact them from any direction, family, friends, workplace, a stranger, and so staff were on high alert wondering ‘is the next patient going to be the one that gives it to me’”* (Participant 17).

When the expected “tsunami” did not eventuate, some mixed feelings were expressed by those interviewed later in the study. Many participants described how lucky and relieved they felt that COVID-19 had not caused the same devastation in Australia as that reported by other countries. However, the huge effort involved in preparing for the expected onslaught led to some unexpected emotions when it did not occur. One participant explained:

Well, we're waiting for the wave to hit us and we don't think it's actually going to hit us now, and now we just feel a bit cheated because actually we're feeling a bit change-fatigued and a bit toey ... And we are really glad it hasn't happened but, at the same time, we did so much stuff... we put into place all this stuff and now we don't need it. (Participant 14).

The other impact of facing the “unknown assailant” was fatigue. The pandemic came at the end of months of catastrophic bushfires in Australia. Already staff were feeling weary, then COVID-19 appeared. The culmination of months of stress began to show and impact upon other aspects of the staff members’ lives. One participant explained:

...at the beginning, they were very anxious and using vast amounts of energy and adrenalin in getting ready and ready to fight this assailant. Then by ...the beginning of May they were tired. They had used so much energy and so much adrenalin, they got to the point where they were just exhausted...” (Participant 17).

According to several participants this ongoing weariness led to a heightening of tension both at home and work for many staff.

ii) Isolation and disconnection

According to the participants, one of the biggest impacts of COVID-19 upon patients and residents was the isolation and disconnection brought about by visitor restrictions. As one participant reflected, hospitalisation in any circumstance severs a patient’s connection to people and things that matter to them. Such disconnection was more severe during COVID-19, when family were unable to visit at all, or visits were restricted to a single family member. COVID-19 restrictions left patients “*disconnected from the people that hold [them] in [their] life*” (Participant 1).

The isolation brought about by COVID-19 was particularly felt in aged care facilities, which in many cases went into complete lockdown. Participants observed that those with dementia were more likely to become confused about restrictions or forgot why family members were not visiting. In one aged care facility a resident thought her husband had run off with another woman. For others, distress from previous traumatic experiences was triggered. One participant commented, “*you’re dealing with COVID-19 and you’re dealing*

with all the underlying issues that were always there but were probably suppressed or pushed down” (Participant 2).

Visitor restrictions not only impacted upon patients, but also worried family members. One participant spoke of an agitated family member who was not allowed in to visit his wife, because it was not visiting hours:

And she had been calling him saying ‘please come and see me’. So he had come in and one of the nurses quite rightly said ‘I’m really sorry but you’re not allowed in because it’s not the hours yet’ ...he was shaking with anger. (Participant 34).

According to participants in aged care, some family members wondered whether their relatives would remember them when the lockdown ended. However, several participants observed that older people were often more resilient than families realised and coped very well. One participant said of the aged care residents in her facility: *“they’re very stoic, they’ve been through wars. If something needs to be done for the greater good, it needs to be done for that greater good, and you saw that really come out” (Participant 10).*

Unique challenges were faced by patients, family members and staff when end-of-life issues were present. Participants described how restrictions on numbers at a dying person’s bedside, at the viewing of a body, or in attendance at a funeral, caused extra levels stress for both family members and chaplains. It was very difficult for family members to choose who should witness a patient’s death, *“you have to choose whether Mum or the son is with the relative when they die” (Participant 19).* One participant described how a family member was devastated that only ten people were allowed at her relative’s funeral. One participant described how she had turned a family member away from a funeral because she had a fever. This was upsetting for both the chaplain and the family member involved. State border closures at a national level increased distress levels for family members in other ways. One

participant described how a couple had been required to enter quarantine upon arriving back into their home state with their daughter's body. *"It's just, like, golly, you're sunk in this grief, but you can't quite grieve because you've got all this admin[istration] to do. Other stuff to do before you got to think about the funeral"* (Participant 34). This exacerbated an already very sad situation.

iii) Fear of transmitting the virus

COVID-19 raised particular challenges for healthcare staff regarding transmission of the virus. In many cases these were also experienced by the participants themselves and included fear of bringing COVID-19 home to family members, fear of bringing COVID-19 into their facility or spreading it between patients or residents. This led to some being unable to maintain their own connections with loved ones. A participant with elderly parents told them *"I can't come to visit you for a while, because, I'm a bigger threat to you than anybody else"* (Participant 14). Another spoke of how she thought very hard about whether she could continue her work, due to her elderly husband living at home. Such fears led to increased cautionary measures upon arrival home after a shift, *"I started having showers when I came home and having my clothes washed"* (Participant 21). Staff were also mindful of touching family members because of infection risk. One participant quoted a colleague as saying, *"I miss hugging my husband, I don't get to give him a kiss...I feel like a leper, even when I am in my own home"* (Participant 1).

Alongside a fear of bringing COVID-19 home was the fear of being the person who would take COVID-19 into the hospital or spread it amongst patients. This was particularly the case for those working in aged care: *"I don't want to be responsible for bringing anything in, because it will be devastating. That's by itself a cross, a massive cross"* [to carry] (Participant 2). Another who worked in healthcare remarked *"I don't want to be the person*

on the [television] news having got COVID-19 a week ago from some patient and then I've just spent the week visiting every ward in the hospital" (Participant 4).

The risk of transmitting the virus raised particularly difficult dilemmas for chaplains. One participant spoke of how strongly she felt that it was the right decision *"to go in [and see patients] regardless of the risk"* (Participant 21). And another *"our role as a pastoral care person is to be with the most vulnerable person at the most vulnerable time"* (Participant 33). Yet these decisions to be on the 'frontline' increased the risk to themselves and their family members at home.

3) Chaplains responding to the crisis

Five ways were identified in which chaplains responded to the COVID-19 pandemic: i) providing a calm presence, ii) being available, iii) holding out hope, iv) introducing creative ways to provide spiritual care, and v) seeking spiritual nourishment.

i) Providing a calm presence

Rather than requiring a new response, most of the participants in this study spoke about providing their 'usual care' to patients and aged care residents during the pandemic, as they would to in any crisis. The pandemic was just another "crisis", and as one participant explained *"we're chaplains, it's a crisis. We need to be here, and we need to respond to the crisis well"* (Participant 28). Several spoke of how they had been able to bring calm during the crisis to both patients and staff. *"I can't fix anything; I can just be the calmest person in the room and allow His [God's] hope to infuse the space"* (Participant 4). One participant described how she had given a talk which was recorded and distributed to all staff, as requested by her manager, to *"steady the ship"* (Participant 6). However, providing a calm presence came at a cost for some participants. They expressed how they were reluctant to

share their own fears and worries with staff. As one explained, *“you always have to be calm, you always have to pretty much hold it together”* (Participant 6).

ii) Being available: “I’m here”

An ability to be available for patients, family members, and staff was mentioned by many of the participants. One said of his experience in an aged care facility, *“we were the family, we were everything for them”* (Participant 2). Another said *“Patients are tired, they don’t necessarily want conversation. However, the presence of a person with positive regard is a great comfort to them”* (Participant 4). As one participant explained, during COVID-19 *“that whole thing of providing a safe space has become really, really important* (Participant 15).

Being perceived as a “safe” person to speak to often led to casual conversations in the corridors with other staff. One participant commented *“the greatest thing that they need is just a listening ear, for them to express what they make of what’s happening through COVID-19”* (Participant 2). Staff trusted chaplains with their fears and stories and recognised that *“we’re there for staff as well as patients and that we’re not going to “Bible-bash” them or shove anything down their throats, that we’re just there to be supportive and to listen if that’s what they would like”* (Participant 3). This care was extended to volunteers who had been sent home. One participant reflected how for many of the volunteers, meaning and purpose was found in what they did. It was *“part of their spiritual practice, that they give back to society in their volunteering and all of a sudden, all of their avenues of volunteering just got shut down”* (Participant 14). She described how chaplains had made an effort to provide ongoing support to volunteers, calling them at home.

iii) Holding out hope

One participant described the importance of hope for the staff with whom they worked during the pandemic. She conveyed this in a symbolic way by asking maintenance staff to turn off

the sensor light in her office, thus allowing the light to remain on. Others held out hope by reminding themselves and others of times in history when *“difficult things have happened...it doesn't all progress in a straight line from bad to better, but people do cope and find ways”* (Participant 10).

Several participants spoke about the hope they personally held for the future. Some hoped that the experience of the pandemic would sustain how people engaged with the deeper questions, how they connected with others, and *“not go back to that norm that we had before”* (Participant 9). It was suggested that being forced to *“stop”* might help people to realise that *“this [reflection] is really special, this is something I want to engage more in”* (Participant 1).

I think overall, the pandemic has done for humanity what great challenges have always done, which is it makes us reconsider the important things, reconsider who we are ... and engage with those bigger questions (Participant 19).

The role they played in supporting others helped many chaplains feel that their own lives were meaningful and had purpose, and several shared how much they benefited personally from being in a role where, *“there's some real...purpose in what we do and I actually enjoy it”* (Participant 3).

iv) Introducing creative ways to provide spiritual care

Chaplains drew on creative means to build relationships with patients or residents and staff during COVID-19. These included: providing care to patients and family members without the use of close physical contact and promoting chaplaincy as an essential service for all.

A particularly difficult aspect of the new restrictions was lack of physical touch. Even when visiting patients face-to-face, chaplains were expected to maintain a 1.5 metre distance. One participant described how this challenged the way they would usually work:

...so we [usually] hold people's hands when we're praying, we'll put a hand on their back if that's what they want, some people when they're in real distress they just want someone to hold them and so [not being able to] touch has been something that's been a challenge for us through this ...someone is howling in front of you because their mother's just died and they need a hug (Participant 17).

Others spoke of how they had sometimes quietly ignored these restrictions: “*we've probably crossed the boundary...I think most of us would say that we've hugged people when we shouldn't have*” (Participant 17). However, some thought of creative ways to overcome this issue without breaching the regulations, “*...we actually made a little card saying 'this is a virtual hug' [laughs]. We were handing those around which added light to what was a really hard reality (Participant 4)*”. Another described how she would touch the covers of a patient's bed, rather than touch the patient themselves, and used this to convey similar care.

In some organisations electronic devices was introduced to overcome some of the challenges associated with reduced face-to-face contact. For instance, use of iPads in aged care facilities led to better facilitation of contact between residents and family members. One participant described how moving it was to see a resident kissing the screen of an iPad as she spoke with her family member. Electronic devices could also increase patients' access to chaplains. In one hospital, a text messaging service was established so that patients, family members and staff could contact chaplains remotely. In another, a chaplain was able to maintain contact with patients at remote hospitals who she would not otherwise have seen. The use of an electronic device meant that one chaplain could work from home one day a week and still maintain contact with colleagues.

One chaplain interviewed later in the pandemic was required to wear a mask for all patient contact. She described how uncomfortable this was, and it meant that sometimes

verbal communication was difficult: *“it’s hard when you can’t see somebody’s mouth. And I think it’s very difficult for elderly patients to understand what’s being said”* (Participant 34). However, she also reported that she was able to overcome some of these challenges through body language: *“I use my body to express how my face is feeling, so I’m very conscious of leaning in, focusing or opening up or just reacting and moving to what they’re saying”*. She also commented that patients were quick to accept and adjust to staff wearing masks.

The other notable challenge for chaplains was maintaining and promoting their work even when referrals dropped. Experiences varied among participants, and much seemed to depend on how chaplaincy was perceived by the administration. Some chaplains were considered members of the multidisciplinary clinical team, others were managed by non-clinical departments such as Corporate Services. Some perceived pressure from management to work from home, but feared that *“if we all do that they will tell the hospital we don’t need chaplaincy”* (Participant 21). To promote themselves and make themselves visible participants spoke of working hard *“to get our name out, to get cards on the desk, the ward clerks and things like that, so that they could say we are still here, we are available”* (Participant 28).

In situations where chaplains had built up a strong relationship with staff over several years, the experience was a more positive one. The COVID-19 pandemic brought chaplaincy to the forefront of care, *“and the role of chaplains is now even more appreciated by staff and by patients because we’re seen as essential workers”* (Participant 15). One participant described how other healthcare staff appreciated them more as they were providing a service that others did not have the time to provide. Some arranged coffee vouchers for staff, and two from different hospitals described putting up words of positive encouragement in posters around the hospital, such as *“we will get through this”* (Participant 14). One pastoral care manager described how he built relationships with staff by *“bringing in treats with little*

encouragements and visiting every nurse manager in the two hospitals in which I work, and it gets me into their office every week, and I sit down and I talk with them” (Participant 1).

v) Seeking spiritual nourishment

The ongoing nature of the pandemic meant that it was important for chaplains to consider how their own needs for spiritual nourishment were met. This was often a challenge. One participant mentioned how a colleague told them *“I feel barren, I feel dry, and I feel un-replenished”* (Participant 1). Holidays were not an option (due to government travel restrictions), though they were needed: *“it’s been a struggle not being able to have a break or get away or anything like that. I think a nice holiday probably would have been great in this time”* (Participant 28). For another, protecting patients from the virus meant temporarily giving up visiting the park with her dog, a daily routine she had previously enjoyed. Some found it hard not to compare themselves with others: *“Most of the ministers have gone home and they are nice and safe and cosy in their houses, phoning people. But I’m out on the frontline, and I’m feeling extra vulnerable”* (Participant 14). And another reflected *“so I am thinking at the end of this everyone [else] will be really rested and have this great new direction and some of us will just be tired and keeping going”* (Participant 6).

Chaplains nourished their own needs during the pandemic by going on bushwalks, gardening, continuing to exercise, meeting with friends and other pastoral colleagues online, taking time off when needed, prayer, listening to podcasts, making soup, reading and journaling. Several participants spoke of their own faith. They spoke of trusting God, even though they did not necessarily understand the situation. One shared:

I have felt, because of the enormity of the situation, I’m going through the motions a little bit with my walk with God. But I still trust him through this situation. He’s in control. I

find comfort and strength in that, and that one day things will be better either in this world or the next (Participant 28).

Discussion

This study considered the impact of the COVID-19 pandemic from the perspective of Australian health and aged care chaplains. The grounded theory analysis revealed that COVID-19 firstly impacted health and aged care facilities at an institutional level. This created a range of challenges for patients, residents, family members and staff by increasing fear and anxiety of an outbreak in Australia, creating isolation and disconnection, and raising fears of virus transmission in health and aged care facilities. Chaplains responded to this crisis by providing a calm presence, being available, holding out hope, introducing creative ways to provide spiritual care and seeking spiritual nourishment for themselves.

The findings of this study complement an earlier Australian study, on the impact of the COVID-19 pandemic upon spiritual care in an aged care setting (Drummond & Carey, 2020). Drummond and Carey observed that the fear of a COVID-19 outbreak in Australia led to physical, psychological, social and spiritual ramifications for patients and their family members within an aged care context. Likewise, this current study found that the fear of COVID-19, and the subsequent restrictions, led to a range of challenges for patients, family members and staff. Of particular note, in both studies the need for chaplains to adapt to new ways of providing spiritual care became paramount.

One of the issues highlighted in this study was the way chaplains had to adapt to provide spiritual care to patients, family members and staff, when strict guidelines on physical distancing were imposed. While no chaplains in this study reported having to work from home on a permanent basis, there were restrictions on how often they could visit wards, and how much physical contact they could have with patients. One solution, use of electronic

devices, brought both challenges and opportunities. The benefits of using such devices have been previously documented (Byrne & Nuzum, 2020; Swift, 2020). Byrne and Nuzum (2020) suggested that the use of technology provides significant benefits for healthcare chaplains, including the ability to provide pastoral care in a safe way, reducing the spread of infection, facilitating contact with family members, and reducing the necessity for otherwise essential protective equipment. Another study (Swift, 2020) concluded that, while spiritual care provided remotely could be beneficial in some cases, in many situations a physical presence was preferable. Our study similarly reported mixed findings. Drawbacks of using electronic devices included: patients being too unwell to use them, chaplains missing cues or signs of distress that they would normally pick up, and chaplains being unable to build the usual rapport with patients. For others the introduction of technology provided new opportunities for connection. For most, a mix of both was preferred. Participants were aware that new avenues of communication had opened that could persist after the crisis, promising future opportunities to expand their reach.

An associated aspect of reduced contact with patients in hospital wards meant that chaplains needed to rely upon other staff members for referrals. This was challenging at times due to the increased workload other staff, such as nurses, were taking on. For other participants this did not pose an insurmountable challenge, due to the strong relationship they already had with other staff. A good understanding of the role of chaplaincy also helped, and this finding is supported by others (Cohen, 2018; Damen et al., 2019; Poncin, Niquille, Jobin, Benaim, & Rochat, 2020). One way shown to improve referrals to chaplaincy is spiritual care training for other members of the healthcare team (Vlasblom, van der Steen, Knol, & Jochemsen, 2011). Such training may be an important component to support chaplaincy involvement in patient care, both during and beyond the pandemic.

Related to understanding of the chaplaincy role, was how the COVID-19 pandemic environment could heighten the value placed on chaplaincy within the health and aged care systems. Some participants felt more appreciated during the pandemic and were able to offer a “safe” presence for staff who were fearful or anxious. The ability of chaplains to just sit and listen to patients who could no longer have family members visit was highly valued by both the patients themselves and staff who did not have the time to do so. These findings replicate other studies which have explored the role of chaplaincy in usual times (Best et al., 2020; Damen et al., 2020; Handzo et al., 2008; Taylor, Hodgson, Kolobova, Lamson, & Sira, 2015). This suggests that, while the COVID-19 pandemic has created a crisis on a world-wide scale, the tools for dealing with this situation lie within the chaplain’s standard expertise.

This study had several limitations. It was conducted in a country where the morbidity and mortality rates associated with COVID-19 are relatively very low. The experiences of chaplains may be different in other countries, where the impact of the pandemic has been much greater. Furthermore, the range of religious and ethnic backgrounds represented in this study was limited. For these reasons, the results of this study may not be generalizable to other contexts, and further research to explore different perspectives would be beneficial.

The COVID-19 pandemic has brought spiritual care to the forefront of healthcare. What does it mean to be a chaplain in a global crisis? How does one care for others, while also caring for oneself? The findings in this study revealed that in Australia, chaplains have played a significant role in caring for hospital patients, aged care residents, family members, and staff during the COVID-19 pandemic. Their calm presence, ability to be available during a crisis, creativity, and hopeful orientation, all provide an important role in health and aged care. However, it also is apparent in this study that to maintain this caring presence, chaplains need to sustain their own spiritual well-being. Management has an important role to play in supporting chaplains, and ensuring their service continues to be available to all.

Funding Details

The first author is undertaking an Early Career Research Fellowship, funded by St Vincent's Health Australia and the University of Notre Dame Australia.

Acknowledgements

The authors would like to sincerely thank all the participants who were interviewed for this study.

Declaration of Interest

No potential competing interest was reported by the authors.

References

- ABC News. (2020, May 19). Australia's coronavirus death tally hits 100 after a woman dies in NSW nursing home Newmarch House. *ABC News*. Retrieved from <https://www.abc.net.au/news/2020-05-19/coronavirus-death-toll-hits-100-in-australia/12213568>
- Best, M., Washington, J., Condello, M., & Kearney, M. (2020). 'This ward has no ears': Role of the pastoral care practitioner in the hospital ward. *Journal of Health Care Chaplaincy*, 1-15. doi:<https://doi.org/10.1080/08854726.2020.1814089>
- Borrello, E. (2020, March 15). Italy's coronavirus outbreak poses warning about the impact of COVID-19 on the healthcare system. *ABC News*. Retrieved from <https://www.abc.net.au/news/2020-03-15/italy-coronavirus-warning-about-impact-of-covid-19/12052578>
- Briggs, C. (2020, May 15). As coronavirus cases rise in Victoria, how do we know when a second wave is starting? *ABC News*. Retrieved from <https://www.abc.net.au/news/2020-06-20/coronavirus-second-wave-australia-victoria/12372938>
- Brunier, A., & Drysdale, C. (2020, October 5). COVID-19 disrupting mental health services in most countries, WHO survey. *World Health Organisation*. Retrieved from <https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey>
- Byrne, M., & Nuzum, D. R. (2020). Pastoral closeness in physical distancing: The use of technology in pastoral ministry during COVID-19. *Health & Social Care Chaplaincy*, 8(2), 206-217. doi:<https://doi.org/10.1558/hsc.41625>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications Limited.

- Cohen, J. (2018). How is chaplaincy marginalised - by our faith communities and by our institutions and can we change it? *Religions*, 9(24), 1-6.
doi:<https://doi.org/10.3390/rel9010024>
- Damen, A., Labuschagne, D., Fosler, L., O'Mahony, S., Levine, S., & Fitchett, G. (2019). What do chaplains do: The views of palliative care physicians, nurses, and social workers. *American Journal of Hospice & Palliative Medicine*, 36(5), 396-401.
doi:<https://doi.org/10.1177/1049909118807123>
- Damen, A., Murphy, P., Fullam, F., Mylod, D., Shah, R. C., & Fitchett, G. (2020). Examining the association between chaplain care and patient experience. *Journal of Patient Experience*, 1-7. doi:<https://doi.org/10.1177/2374373520918723>
- Drummond, D. A., & Carey, L. B. (2020). Chaplaincy and spiritual care response to COVID-19: An Australian case study-the McKellar Centre. *Health & Social Care Chaplaincy*, 8(2), 165-179. doi:<https://doi.org/10.1558/hsc.41243>
- Ferrell, B., Handzo, G., Picchi, T., Puchalski, C., & Rosa, W. E. (2020). The urgency of spiritual care: COVID-19 and the critical need for whole-person palliation. *Journal of Pain and Symptom Management*, 60(3), e7-e11.
doi:<https://doi.org/10.1016/j.jpainsymman.2020.06.034>
- Handzo, G., Flannelly, K., Kudler, T., Fogg, S., Harding, S., Hasan, Y., . . . Taylor, B. (2008). What do chaplains really do? II Interventions in the New York chaplaincy study. *Journal of Health Care Chaplaincy*, 14(1), 39-55.
doi:<https://doi.org/10.1080/08854720802053853>
- Harrison, S., & Scarle, J. (2020). How are chaplaincy departments responding amidst the COVID-19 pandemic? A snapshot of UK responses to a questionnaire. *Health & Social Care Chaplaincy*, 8(2), 143-153. doi:<https://doi.org/10.1558/hsc.41624>

- Holmes, C. (2018). Towards national consensus: Spiritual care in the Australian healthcare context. *Religions*, 9, 379. doi:<https://doi.org/10.3390/rel9120379>
- Mayers, L. (2020, March 20). Aged-care facilities ban visitors because of coronavirus pandemic. *ABC News*. Retrieved from <https://www.abc.net.au/news/2020-03-20/coronavirus-aged-care-facilities-ban-visitors/12072402>
- Minichiello, V., Aroni, R., & Hays, T. (2008). *In-depth interviewing: Principles, techniques, analysis*. Sydney: Pearson
- Morton, A. (2020, March 28). Australia's private hospitals face closure after coronavirus causes elective surgery ban. *The Guardian (Australian edition)*. Retrieved from <https://www.theguardian.com/world/2020/mar/28/australias-private-hospitals-face-closure-after-coronavirus-causes-elective-surgery-ban>
- Newby, J. M. (2020). Acute mental health responses during the COVID-19 pandemic in Australia. *Plos One*, e0236562. doi:<https://doi.org/10.1371/journal.pone.0236562>
- O'Sullivan, D., Rahamathulla, M., & Pawar, M. (2020). The impact and implications of COVID-19: An Australian perspective. *The International Journal of Community and Social Development*, 2(2), 134-151. doi:<https://doi.org/10.1177/2516602620937922>
- Poncin, E., Niquille, B., Jobin, G., Benaim, C., & Rochat, E. (2020). What motivates healthcare professionals' referrals to chaplains, and how to help them formulate referrals that accurately reflect patients' spiritual needs. *Journal of Health Care Chaplaincy*, 26, 1-15. doi:<https://doi.org/10.1080/08854726.2019.1582211>
- Swift, C. (2020). Being there, virtually being there, being absent" Chaplaincy in social care during the COVID-19 pandemic. *Health & Social Care Chaplaincy*, 8(2), 154-164. doi:<https://doi.org/10.1558/hsc.41870>
- Taylor, J., Wilkinson, D. & Cheers, B., Hodgson, J., Kolobova, I., Lamson, A., & Sira, N. (2015). Exploring the phenomenon of spiritual care between hospital chaplains and

hospital based healthcare providers. *Journal of Health Care Chaplaincy*, 21, 91-107.

doi:<https://doi.org/10.1080/08854726.2015.1015302>

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., & Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *International Journal of Social Psychiatry*, 66(4), 317-320. doi:<https://doi.org/10.1177/0020764020915212>

Vlasblom, J. P., van der Steen, J. T., Knol, D. L., & Jochemsen, H. (2011). Effects of a spiritual care training for nurses. *Nurse Education Today*, 31(8), 790-796.

doi:<https://doi.org/10.1016/j.nedt.2010.11.010>

Woodley, M. (2020, September 8). How does Australia compare in the global fight against COVID-19? *Royal Australian College of General Practitioners*. Retrieved from <https://www1.racgp.org.au/newsgp/clinical/how-does-australia-compare-in-the-global-fight-aga>

World Health Organisation. (2020). WHO Coronavirus Disease (COVID-19) Dashboard. Retrieved from <https://covid19.who.int/>

Table 1: Demographic details (N=17)

Item	N (%)
Gender	
▪ Male	6 (35.3)
▪ Female	11 (64.7)
Age Group	
▪ 20-29	0 (0.0)
▪ 30-39	1 (5.9)
▪ 40-49	3 (17.6)
▪ 50-59	10 (58.8)
▪ 60 or above	3 (17.6)
Years of work experience: M (SD)	11.06 (8.01)
Role	
▪ Spiritual care practitioner	11 (64.7)
▪ Spiritual care manager	6 (35.3)
Setting	
▪ Inpatient care	13 (76.5)
▪ Inpatient and Community	1 (5.9)
▪ Aged Care (residential)	3 (17.6)
Ethnicity	
▪ Australian	15 (88.2)
▪ European	1 (5.9)
▪ Asian	1 (5.9)
Religious affiliation	
▪ Christian	16 (94.1)
▪ Unitarian	1 (5.9)
I am a spiritual person	
▪ Strongly agree	16 (94.1)
▪ Agree	1 (5.9)
▪ Neither agree nor disagree	0 (0.0)
▪ Disagree	0 (0.0)
▪ Strongly disagree	0 (0.0)
I am a religious person	
▪ Strongly agree	4 (23.5)
▪ Agree	6 (35.3)
▪ Neither agree nor disagree	5 (29.4)
▪ Disagree	2 (11.8)
▪ Strongly disagree	0 (0.0)
Spiritual training	
▪ Certificate/Diploma	5 (29.4)
▪ Bachelor or Master's degree	12 (70.6)

Appendix: Interview questions

- 1) What is human spirituality and how does it help people in times of challenge, crisis and uncertainty?
- 2) What are some of the physical, emotional, social and spiritual challenges currently faced by your clientele/patients/residents because of Covid-19?
- 3) How are chaplains responding to this crisis?
- 4) What are some of the challenges faced by chaplains (and other healthcare workers) who provide support in these contexts?
- 5) What are some ways to sustain yourself spiritually or continue spiritual connections during a time of social isolation?
- 6) What gives you hope in this current situation?