Received: 1 November 2021 | Revised: 12 January 2022 | Accepted: 8 February 2022

DOI: 10.1002/hpm.3443

RESEARCH ARTICLE

WILEY

Towards a national strategy for the provision of spiritual care during major health disasters: A qualitative study

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Funding information

Burdett Trust for Nursing, Grant/Award Number: SB\ZA\101010662\649037

Abstract

Background: Spirituality is beneficial to health. Evidence around the benefits of Spiritual care (SC) is advancing, and training is becoming part of healthcare professional development. As the COVID-19 crisis showed, during major health disasters (MHDs), the demand for SC grows exponentially, while the burden of care and focus on preserving life often hamper its provision. Nonetheless, existing health emergency strategic frameworks lack preparedness for the provision of SC.

Aim: The aim of this study was to identify the components for a National Strategy (NS) for the provision of SC during MHDs.

Methods: Descriptive, cross-sectional, qualitative phenomenological design based on individual, semi-structured e-interviews with nursing managers and National Health Service/volunteer chaplains based in England. Thematic analysis of 25 e-interview data was performed based on a dialogic collaborative process.

Results and Discussion: Eleven themes were identified as components of the proposed NS. From these components, specific recommendations for practical actions are provided.

An integrated framework approach and smart investments in resources, staff training and technologies should be led by the paradigm of culturally competent and compassionate care.

Conclusion: The need to have strategic frameworks, both national and local, that better equip a country healthcare sector to prevent, face, and recover from MHDs is paramount. Catering for the spiritual needs of the affected population should be a key aspect of any health emergency strategy to ensure the preservation of quality care.

KEYWORDS
England, major health disasters, national strategy, NHS, preparedness COVID-19, spiritual care

Highlights

- Adequate provision of Spiritual care (SC) is more needed yet challenging during health disasters.
- With the COVID-19 crisis, SC strategic planning proved essential.
- Collaboration, communities' inclusivity, and training are key strategic elements.
- Governments investments should look at advanced technologies, and material and human resources.

1 | INTRODUCTION

According to the United Nations, cataclysmic events worldwide have tripled since 50 years ago.[1] Between 2000 and 2019, the Emergency Events Database of the Centre for Research on the Epidemiology of Disasters, recorded 7348 disasters which claimed a total of approximately 1.2 million lives.[2] Within all types of disasters, major health disasters (MHDs) are also on the rise,[3] continually testing the resilience of health systems.[4,5] MHDs tremendous impact can be seen in the destruction of health facilities, with a drastic reduction of essential medicines and healthcare workers,[6,7] as well as in the outbreak of communicable diseases and psychosocial problems.[8] International organisations urge governments to strengthen strategies for disaster reduction and recovery.[9,10] This has now become more pressing than ever, when the COVID-19 pandemic revealed several gaps in governments disaster risk management (DRM).[2(p7),11,12]

Spirituality revolves around the connection of the self with a higher dimension, hence it lacks a univocal definition.[13,14] As a result, spiritual care (SC) encompasses a broad range of interventions and expressions.[15] Several pivotal works have provided valuable insights around both spirituality and SC in nursing and the healthcare sector,[16] however without a focus on SC during MHDs. In a previous study,[17] we concentrated the varied meanings and dimensions of SC into four universal dimensions: (1.) Search for existential meaning; (2.) Search for a power other than the self; (3.) Reference to the soul of the person; and (4.) Links to the holy, sacred, divine, religious. To these core dimensions, we added some individual meanings, such a search for the infinite, a journey towards inner peace, a meaning to illness and shared values. Several practical examples of actions substantiate both the four core dimensions and the individual meanings.[17] We also proposed a conception of SC—which is broader than how it is more frequently conceived in

nursing care—[18,19] and which sees SC as an integral component of holistic, culturally competent and compassionate care.[20-22] Similar to the Interprofessional Model of SC,[23] our conception of SC is intended to apply to all healthcare professionals, from nurses to medical clinicians, and is not restricted to the professional interventions of chaplains.[24]

Beyond the difficulty of having narrow definitions, spirituality and SC have been shown to be beneficial to health outcomes during the past few decades of research across several disciplines and fields, from epidemiology,[25,26] to neuroscience[27] and mental health.[28] The World Health Organisation (WHO) includes the evaluation of and care for the spiritual needs of the patients with life-threatening illness.[29] Several other policy documents and institutional guidelines included SC as key to quality healthcare,[30,31] recommending its inclusion in professional training and practices, for example in the US[32] and the UK.[18,33] SC preparation is increasingly incorporated in nursing curricula and professional development preparation.[34,35] However, SC preparedness appears as almost non-existent in MHDs strategy and DRM.

The relevance of spirituality and SC becomes exacerbated in circumstances of mass and massive fear and death.[36] Nonetheless, as the COVID-19 pandemic demonstrated, the emergency workload, focus on preserving life and infection control measures often hamper its provision.[17,37,38] For this, strategic planning and preparedness become essential. International institutions developed guidelines which include the integration of SC in the response to humanitarian emergencies[39] and major incidents,[40] in recognition of the spiritual suffering caused by disasters. In the US, the hub of Centres for Disease Control and Prevention developed a document on how to safely offer spiritual and psychosocial support to people with COVID-19 at home.[41] In the UK, guidance focuses on how emergency responders can collaborate with faith communities in the planning and preparation for major incidents and pandemics.[42,43] Within the National Health Service (NHS), the Chaplaincy guidelines[44] include recommendations for chaplains to be involved in the response to major incidents. Recently, some guidance has focussed on how SC can be given during the COVID-19 pandemic in an inpatient healthcare setting.[45,46] Despite their usefulness, these documents are not strategic frameworks, and, in the UK, the NHS England programme of work 'Emergency Preparedness, Resilience and Response'[47] lacks plans to prepare the health workforce to put in place and co-ordinate plans for SC.[48]

This article addresses the existing gap in strategic planning and preparedness in relation to the provision of SC during MHDs, and it stems from a study with nurse managers and NHS/volunteer chaplains based in England. Despite the fact that the whole health workforce is under extreme pressure during a health emergency, however, in the field of SC, senior nurses and spiritual leaders bear the greatest responsibility for the patients' and colleagues' spiritual well-being. We acknowledge that nurses' and chaplains' roles in providing SC are different, particularly in non-crisis times. Nurses, like other healthcare professionals, are generalists in SC, whereas chaplains are specialists.[22,49] However, nurses' role in supporting the spiritual well-being of patients is well-established,[18] addressing patients' spiritual needs is considered part of their profession,[50] and nurses and midwives' education standards in SC have considerably progressed.[51-53] For this reason, this study explored NHS nurse managers' and chaplains' experiences and views in relation to SC. This article focusses only on the views of participants about: (1) what worked, (2) what did not work, and (3) what would have worked better, in the provision of SC in England during COVID-19, from March 2020 to July 2021. In this respect, participants were asked questions about: the main issues encountered in SC (Q3); what would have helped and better enabled SC (Q4); and which key elements, protocols and resources a National Strategy (NS) should factor in (Q8&9, see Supplementary Material for the full interview topic guide).

Based on this sub-dataset, this article aims to identify the main components and resulting recommendation for practical actions of a NS for the provision of SC to patients, their families and the health workforce during MHDs.

2 | METHODS

2.1 | Design

A descriptive qualitative phenomenological design,[54] based on individual, semi-structured e-interviews, was chosen.

2.2 | Sample and setting

A purposeful sampling method was used, based on convenience, emergent and snowball sampling strategies.[55] A list of relevant professionals guided recruitment. The list was based on the previous scoping review conducted by the research team,[56] their professional networks, and new contacts searched for and selected from the World Wide Web. Recruitment focussed on the inclusion of senior nurses and chaplains from as many regions in England as possible, in line with the study objective for a national reach. Chaplains were also recruited to represent both religious and non-religious views, in line with the declared intra- and non-faith reach of SC in the country.[44(p6)]

Recruitment occurred via emailing; relevant organisations/potential participants were contacted, and upon their expression of interest, further information and ethics documents were shared, and the e-interview was scheduled. Participants were included if they were: a senior nurse/nursing manager, an NHS/volunteer chaplain; based in England; professionally active during the pandemic between March 2020 and June 2021.

A minimum of nine interviews were to be collected from the nursing managers as well as from the chaplains cohort. Twenty-five participants were interviewed in the study: nine senior nurses and sixteen chaplains. The demographic characteristics of the sample are offered in Table 1, and kept essential to protect participants anonymity. In the chaplains sub-sample, 9 out of 16 participants (56%) belonged to the Christian faith, three were Buddhists, and we had one chaplain for each of the following: Humanist, Islam, Jainism, and Judaism. Five participants in the whole sample (20%) belonged to Minority Ethnic Groups (MEGs). After 18 interviews adequate information was reached,[57] but as we wanted to include a greater variety of religious faiths, non-religious affiliations and geographical regions, in the case of chaplains, interviewing continued to ensure variety, sub-samples balance, and full saturation.

2.3 | Data collection

Semi-structured e-interviews were undertaken between the 5 May 2021 and the 9 July 2021. Data were collected using the cloud-based video communications app *Zoom* and the team collaboration platform *Microsoft Teams*. Probing and follow-up questions, such as 'could you elaborate more on this' or 'would you mind giving an example' were used to encourage participants expand their answers, when needed. E-interviews lasted between 35 and 65 min, were audio-video recorded, and the automatic transcription tool was also used. Two research team members conducted the interviews, while four conducted the analysis, either of the audio-file or of the verbatim, anonymised transcripts.

2.4 | Data analysis

Thematic analysis was performed based on a dialogic collaborative process,[58] which was dictated by a pragmatic and purposeful approach aiming to answer the research questions within the project timeline. As described in Paulus and colleagues,[58] the process began with the generation of individual meanings stemming from careful reading/watching and listening to, as well as familiarisation and analysis of the interview transcripts/audio-video recordings. Individual meanings were written down, either digitally or paper-and-pencil on notebooks; they were then brought into the circle of our online weekly team meetings where they were discussed, reviewed, and refined; constant comparison with the whole data was performed. The aim was to generate, as the analysis of more data progressed, patterned group of meanings, which could be incorporated into themes and sub-themes. As the process was iterative, meanings and themes shifted through the collaborative dialogues, up to the definition of the final consensual themes. The overall team's standpoint was informed by a data-driven inductive approach[59,60] and grounded in phenomenological theory.[61] Analysis started soon after the first handful of interviews were conducted and progressed in parallel with data collection. Data analysis concluded on 16 July 2021.

TABLE 1 Key demographic characteristics of participants

Chaplains (participant ID[a])	Region of England	Declared gender	Age range	Years of working experience in current position
1CLBob	London	Male	61–70	6–10
2CEMAda	East midlands	Female	51–60	<2
3CSEEvi	South east	Female	61–70	11–15
4CNWNick	North west	Male	41–50	2–5
5CNWKen	North west	Male	61–70	11–15
6CEMJon	East midlands	Male	51–60	>20
7CY + Dan	Yorkshire	Male	41–50	<2
8CL + Mike	London	Male	>70	>20
9CWMLuke	West midlands	Male	51–60	16–20
10CSWCat	South west	Female	61–70	16–20
11CEM + Norb	East midlands	Male	51–60	2–5
12CLTim	London	Male	51–60	2–5
13CNWFin	North west	Male	41–50	16–20
14CLAmy	London	Female	51–60	>20
15CY&SEInes	Yorkshire and south east	Female	31–40	2–5
16CSEWin	South east	Male	>70	11–15
Senior nurses				
1NSEAnn	South east	Female	41–50	>20
2NNWSusie	North west	Female	51–60	>20
3NNWLiz	North west	Female	51–60	16–20
4NIMNess	Isle of Man[b]	Female	51–60	>20
5NLBeth	London	Female	51–60	6–10
6NLJess	London	Female	61–70	>20
7NLKate	London	Female	51–60	16–20
8NSERosie	South east	Female	51–60	>20
9NLFlo	London	Female	41–50	2–5
Total *N* = 25	London: 8	Female: 14	51–60: 12	>20: 8
	South east: 5		61–70: 5	16–20: 5
	North west: 5		41–50: 5	2–5: 5
	East midlands: 3		>70: 2	11–15: 3
	Yorkshire: 2	Male: 11	31–40: 1	6–10: 2
	West midlands: 1			<2: 2
	South west: 1			
	Isle of Man: 1			

[a]Legend to participant ID. For example 7CY + Dan: 7 = Interviewee's number in chronological order; C/N = Nurse or Chaplain; Y = Initial of the region of England; + = Interviewee has also nationwide professional reach; Dan = Pseudonym.

[b]We acknowledge that the Isle of Man is not an english region, but decided to include this outlier interview because the research team saw no conflict. We had no participants from East of England and North East regions.

2.5 | Rigour

The criteria for excellence for qualitative studies followed were: transferability and dependability, along with methodological excellence and accuracy for credibility and confirmability.[62] Interview questions were piloted, and detected problems with wording and flow were resolved. Each automatically generated transcript was checked and fixed by a researcher, and then sent to the interviewers to double check accuracy and anonymisation. The research team continually discussed and critically reflected on recruitment strategy, on each interview conducted and its analysis. To enhance credibility and confirmability, quotes are reported to ground and evidence the results (see Table 2). Note-taking, Word document with figures and text, as well as meeting recordings kept trail of data collection and analysis.

2.6 | Ethical considerations

The study was carried out in accordance with the Middlesex University Code of Practice for Research and followed the university Research Ethics Review Framework. Ethical approval was granted by the Middlesex University's Health and Social Care Ethics Sub-committee (#17428 of 27.4.21). Potential participants who responded with interest to the recruitment letter were sent the Participant Information Sheet and the Informed Consent Form. Participation was anonymous, confidential, and completely voluntary and participants could withdraw from the study at any time without providing a reason. All documents were anonymised except the audio-video interviews' recordings and the consent forms which were kept encrypted and password protected in a secure university *OneDrive* platform.

3 | RESULTS

The analysis of e-interview data led to the identification of 11 themes, and several sub-themes. These themes constitute the components of a NS for the provision of SC in MHDs, as resulted from this study, and informed practical recommendations for action (Table 2). The themes/components are:

Awareness of the past. Participants shared poignant stories of their frontline work during the pandemic, while also giving examples of good practices which rose from collaborative and adaptive responses to an unprecedented situation. In the lack of guidelines and preparedness for SC provision in major incidents that all participant reported, the importance of having a pro-active leadership was mentioned.

Terminology. In light of ongoing misunderstandings, the need for clear and shared definitions of key terms, such as SC and chaplaincy, was an issue that almost all participants raised.

Communities. Engaging with communities with different cultural backgrounds provided opportunities to work with and empower people and their locality. Some participants expressed that resilience was fostered when the NHS, the local authorities and communities worked together for the common good.

Collaborations. The pandemic enhanced collaborations around SC, with local faith and non-faith communities, and within NHS Trusts. This led to the establishment of multidisciplinary teams working together towards staff and patients well-being, including patients' referrals and the allocation of resources.

Communication. The above two themes are necessarily bound to the issue of communication. During the pandemic many levels of communication were in operation (e.g., between clinical and non-clinical staff, patients, families, management, etc.), as well as different types were used, especially non-verbal, symbolic and virtual communication.

Trust. Participants reported the lack of and/or sudden changes of protocols and information given. This poor quality and consistency in information giving resulted in loss of trust among the public and the healthcare workforce.

Extra SC. Participants reported that the demand for SC increased dramatically among staff and relatives. In hospitals, staff SC initiatives were numerous, and the support needs of more vulnerable groups in the community had to be

TABLE 2 Summary of study results, with themes/components, relative sub-themes/components and quotes, and recommendations for the national strategy (NS)

Themes/components	Sub-themes/components	Quotes (participant ID[a])	Recommendations for a national strategy
Awareness of the past	Stories Good practices Proactive leadership	'The COVID wards were quiet and the only thing you could hear sometimes was only the beeping of the machines that was pumping the air and the oxygen, it was really eerie and post-apocalyptic.' (15CY&SEInes) 'One thing that happened was that spiritual and pastoral care, staff well-being, organisational development, occupational health, and psychology all came together. I know that at the height, our deputy lead was in daily team meetings with them, looking at how we were going to respond to what was going to happen.' (2CEMAda)	• Create an open access archive of stories and good practices.
Terminology	Spirituality Spiritual care (SC) Chaplaincy Chapel	'Spiritual care entails search for meaning, significance, wholeness, integration, self-worth, need for expression and creativity, sense of the sacred, forgiveness, hope, strength, trust, transcendence, felt sense of connectivity with our own ground of being our experience and others. And then you have the religious faith-specific rights and rituals, ministering, and depending on circumstances, blessings, dealing in prayers, chants, covering multiple traditions and practices, intra-faith, as well as other faiths, again sitting with dying patients for weeks.' (5CNWKen) 'A lot more staff realised that we were there for them, that we just weren't there for patients…. yes, we're there if someone has a particular religious need, but the vast majority of our work is more spiritual. It's about the universals that we all have, that need to have a sense of meaning and purpose, of all the big questions, that's been important but ongoing. So breaking down some of those misunderstandings about what we're there for amongst staff has been really positive this year.' (2CEMAda)	• Develop clear definitions of spirituality, SC, chaplains and chaplaincy, hospital chapels. • Integrate the provision of SC in all policies related to MHDs. • Develop a spiritual/religious assessment and recording tool of SC needs and interventions. • Include hospital chaplains as members of clinical multidisciplinary teams.

(Continues)

TABLE 2 (Continued)

Themes/components	Sub-themes/components	Quotes (participant ID[a])	Recommendations for a national strategy
Community	Engagement Empowerment Culture	'Different communities had different spiritual needs which related to spaces for contemplation, places of wellbeing awareness, food, and ways through which their voices were heard.' (13CNWFin) 'I wrote to all the faith leaders when the lockdown started, and I said "we're there to help", and tried to be quite open with that, rather than saying that you can't come in, I was trying to say "look, we're here to help". I think that was well-received and generated a lot of support and a lot of calls.' (4CNWNick)	• set out guidelines on the engagements of volunteer faith leaders during MHDs. • Develop of an integrated community SC plan with the involvement of NHS services, local authorities and the third sector. • Involve faith communities leaders and the general public around the development of context-centred policies for SC during MHDs. • Train first SC responders.
Collaborations	Referrals MDT (multi-disciplinary teams) Resources	'When we went to visit someone, we did check with the clinical staff about whether it was appropriate for us to be with the patient.' (6CEMJon) 'The pandemic gave me quite a lot to reflect on our collaborative way of working…not just collaborating with the people in our team, but also collaborating and using those around us. And it was interesting how that experience kind of impacted the members of staff and they felt quite privileged to have been able to care for their patient in a very non-clinical way." (3CSEevi)	• Design protocols for collaborations across different teams in the Trusts, including the establishment of a MDT steering group. • Plan resources and tools for local and workplace communities to collaborate and to develop resilience.
Communication	Confidence Narrate the smile New methods	'Some of our most poignant conversations have been with the cleaners and the security guards, because they have to be very present, they are aware of what's going on. We have some lovely interactions with them, we're all human, and what's going on around us affects everybody, and I think this particular pandemic, there's no boundaries between what's happening in hospital and what's happening at homes. So, we put some stones in the chapel with some words on them like "love", "hope", and "peace", and one of the security guards came in and said he'd like to take one for his daughter. And it was quite an eye-opener as to how much people observed, and carried the burden as a whole organisation, really.' (4CNWNick)	• Enable the communication of SC through the production of key documents for different target audience and in different languages. • Provide adequate communication means and technologies, which are safe and user-friendly. • Create an archive of creative approaches to symbolic communication in SC.

TABLE 2 (Continued)

Themes/components	Sub-themes/components	Quotes (participant ID[a])	Recommendations for a national strategy
Trust	Public confidence Staff confidence	'Although we were morally obliged to follow national policy of no family visits, I broke the rules many times because I could see that families had the right to say good-bye to their loved one. We should have a balance between compassion and safety.' (8NSERosie)	• Produce protocols for SC in MHD. • Keep the staff and the public up-to-date with reliable and accessible information and operating procedures.
Extra spiritual care	Staff Patients Relatives Vulnerable groups Debriefing Protocols and practices	'We would need better ways to keep contact and provide support to bereaved families, because families weren't coming into the hospital and everything was being done over the phone. In normal times, we would be able to at least give families a little leaflet that says various points of contact for support, whatever that support may be. But if you can't do that physically, it might be about learning how we could give that important information to relatives digitally, of how they could make contact with us.' (3CSEEvi) 'We had a lot of Indian and African nurses coming in due to the additional recruitment, and they will obviously have to stay in isolation because of recently coming from India and Africa: they were alone and we had to support those staff differently. Also, some of our southeast Asian and Chinese staff were getting abused because they were seen as the ones who brought COVID to the world: you had all of these complexities happening.' (13CNWFin)	• Plan funds and protocols needed for implementation of extra SC for staff, patients and vulnerable groups. • Identify ways to enable families stay in contact with the patients. • Develop SC information packs (hard copies and digital) which include contact details of hospital chaplains, faith leaders, and other local and national resources on SC.
Technology	Virtual services and support Technology for relatives AI and robotic devices	'We were fortunate that we were given iPads and iPhones as well. I know that my colleagues who were shielding, were able to use those to provide support for patients, for families, and found that really helpful, because it meant that they felt able to be part of things.' (2CEMAda) 'What has worked really well, I think, they're called portals, and the thing about portals is that it's just end to end. So I think those and voice operated AI systems, where if the person has mental capacity and they're able to say "Can you phone my granddaughter", or a surgery or whatever else it is. So I think technology offers a lot.' (11CEM + Norb)	• Trained SC provider on the use of ICTs, and AI devices. • Empower Internet infrastructures in hospitals and faith communities. • Invest in research and development in AI and other robotic devices in healthcare, as well as workforce training.

(Continues)

TABLE 2 (Continued)

Themes/components	Sub-themes/components	Quotes (participant ID[a])	Recommendations for a national strategy
Equality, diversity and inclusion (EDI)	Culturally competent care Fair visiting policies	'Religious care for minority faiths during COVID was disabled. Volunteers' access to hospital was taken away, and volunteer chaplains were only occasionally called by an NHS chaplain with a good heart so to take care of minority faiths' patients.' (1CLBob) 'We were quite regularly reviewing the visiting policy to assess whether we were doing the right thing, telling families not to come in, and whether we needed to make exceptions, and how did that. It's quite a chaotic way of working. I'm not sure it is sustainable. I also do worry that there was some inequality in the decisions we made around which visitors could come in and who couldn't.' (4CNWNick)	• Ensure the implementation of EDI and cultural competence principles in all SC-related documents and resources. • set out clear and equitable guidelines for visitors, so to avoid health risk, moral injury and solitary deaths.
Resources	Spirituality and well-being spaces Workforce Protective/safety devices Care for the dead	'When we came into social distancing that meant that actually we didn't have enough space for staff to sit around to have a break for everything….So we quickly created garden spaces outside which were around the idea of well-being and spiritual needs.' (13CNWFin) 'When the first peak of the pandemic arrived, the nursing workforce was suddenly reduced by 40% due to illness and shielding….and at this point in time only 70% of the staff have been vaccinated due to reluctance and uncertainty about the effects of the vaccine.' (6NLJess)	• Create new or rebrand existing spaces for staff and visitors' spirituality and well-being. • Plan procedures to rapidly deal with the sudden reduction of workforce. • Design protocols and resource for bereaved family members and healthcare workforce.
Training	Values and meanings Protocols and practices	'Thus far the spirituality training for nurses has been very superficial. There is very little content on pain and suffering in the nursing curriculum. We must turn this experience [COVID pandemic] into learning.' (8NSERosie) 'The strategy should include training items about moral injury and ethical decision making [through] the use of stories and experiences from the COVID pandemic.' (9CWMLuke)	The training should include all themes/components discussed above, such as: • Stories and good practices from the pandemic. • A set of spirituality competences which are culturally appropriate and address EDI. • Moral injury and ethical decision making. • The use of technology to deliver SC.

[a]Legend to participant ID. For example 7CY + Dan: 7 = Interviewee's number in chronological order; C/N = Nurse or Chaplain; Y = Initial of the region of England; + = Interviewee has also nationwide professional reach; Dan = Pseudonym.

taken into account too. Debriefing emerged as an important support practice to heal the psychological and spiritual scars of the pandemic experience.

Technology. The use of information and communication technologies (ICTs) proved to be central in the provision of SC. Examples are virtual professional SC, including religious practices, as well as patient-relatives support. The usefulness of as well as the challenges of usini artificial Intelligence and other more advanced technologies were mentioned.

Equality, *Diversity*, *Inclusion* (*EDI*). EDI was raised by several interviewees, often in relation to faith minorities patients not having their religious support needs met due to hospitals visiting restrictions.

Resources. The issue of resources runs through almost all other themes, and was constantly raised by participants, in particular in relation to workforce, reduced funding, inadequate planning and stores of safety equipment, and resources to care for the dead.

Training. Participants expressed that all who work in the healthcare sector should have access to SC training. The training should include awareness raising around universal and the culturally specific values which underpin SC, as well capacity building around the use of a spiritual assessment and recording tool, and around other MHDs-related issues, such as that of moral injury.

4 | DISCUSSION

This study provides further evidence on significant shortcomings in the planning and management on behalf of the health system in England in front of the COVID-19 pandemic.[63] The unique focus of this study has been the domain of SC, where health system's unpreparedness was exceptionally palpable. Results are aligned with the existing state-of-art in health disaster preparedness. Efforts by the same WHO, several organisations as well as state and local jurisdiction have addressed MHDs planning; however, disease outbreaks, including the COVID-19 pandemic,[64] have demonstrated the need to improve decision-making frameworks and to align existing guidelines into one useful tool for governments ongoing planning and response efforts.[2] Furthermore, as flagged up in the current Sendai Framework for Disaster Risk Reduction 2015–2030,[65] the necessity to adopt an all-hazard and whole-of-health approach to DRM and to strengthen national health systems[66-68] has been turned into an urgent matter in light of the COVID-19 test. This study echoes these recommendations, highlighting the alarming mismatch between SC provision unpreparedness, on the one hand, and the exacerbated need for SC in times of MHD across the healthcare workforce, patients and their families, on the other hand. For this, and despite being based on a small study sample, this study has made the case for SC to be included as an important component of any strategic framework for DRM.

In the absence of strategic preparedness, health workforce poignant experiences and adaptive initiatives become the most priceless lessons towards MHDs strategic framework in relation to SC. While the analysis of our e-interviews data led to the identification of detailed components for the strategy, we here discuss them under three main overarching and interconnected lessons to be learnt. The first lesson is about the necessity to adopt an integrated framework approach in all the three main areas of the strategy: planning and preparation; delivery and implementation of the actions/resources needed; and the evaluation of the actions taken.[69] National government departments, non-governmental national/local bodies and faith/non-faith communities, NHS Trusts and their personnel, local authorities and the public, all have a role to play in the collaborative development of the strategy. Integrated care is an existing model in NHS England, where integrated care systems—that is partnerships between organisations coordinating services, plan to improve population health and reduce inequalities—[70] are scheduled to serve all areas of England.[71] As also similarly recognised in the NHS,[72] our results point to how the pandemic magnified the importance of local communities, collaborations and good communication, including towards to the establishment of higher levels of trust on behalf of the workforce and the public.

Lack of trust was indeed found as an important missing element during the outbreak, as other scholars highlighted.[73] In times of public health emergency, the importance of making staff feel supported and cared for is exac-

erbated.[74] Supporting staff should be an ethical imperative of a compassionate health system, and together a way to reduce mental health problems and/or staff loss.[75,76] In our results, we could read how the pandemic emphasised, and sometime also accelerated, valuable processes, such as multidisciplinary collaborations inside Trusts,[77,78] the engagement with local communities,[79,80] and the expansion of the borders of communication in SC.[17,81]

The second lesson to be learnt is that SC preparedness must be underpinned by the paradigm of culturally competent and compassionate care,[20] which has been shown to be of paramount importance in EoL care.[22,82,83] This paradigm is connected with principle of equality, diversity and inclusion EDI that should underpin all strategic areas. Our results indicate how the pandemic unveiled deep seated misconceptions, malpractices, and structural inequalities. In this respect, participants mentioned widespread misunderstanding around: the meaning and practices of SC[19] and chaplaincy; patients' spiritual needs recording and assessment tools, which are either non-existing or adopt non-inclusive terminology; and minority faith SC providers and receivers, who are more vulnerable to structural discrimination in relation to majority faiths (i.e., Christianity in the case of England). Thanks to our effort to include a greater variety of religious and non-religious affiliations of chaplains involved in our study, we achieved a good representation of the minority religions in England. However, our sample still reflects a structural inequality in relation to religious and linguistic inclusivity of SC offer in the country, as well in relation to MEGs representation in the NHS employees' senior ranks. Each national, regional, and local context, and even hospital,[84] is unique. Any MHDs strategy should factor in of the local historical, cultural and socio-economic features characterising application setting, and should pay particular attention to specific minority and vulnerable groups.[85] Terminological and role clarity should be based on participatory consultations and awareness raising actions. This is key in order to achieve an understanding of SC as a fundamental right of the individual within the model of person-centred quality care.[86,87]

The third lesson impinges on the idea of a triple farsighted investment. This refers to the need for governments to make smart investment in: (1) research and development in the field of advanced technology to accelerate their deployment in the healthcare sector. Growing research is demonstrating the potential of ICTs, including the advanced technology of socially assistive robots,[88] in spirituality/religion; (2) material resources, such as hospital design, public/personal protective equipment, and other infection control means, which are staff- and users-friendly, but also inclusive, equitable and sustainable[89]; (3) human resources. Protocols are needed to rapidly deal with the sudden reduction of the workforce, the higher levels of pressure they work under, and their training and preparedness—which should span from the field of advanced ICTs to self-care techniques. In this way, health workforce will acquire more resilience towards the inevitable spiritual and moral wounds that all public health emergencies bring along.

5 | CONCLUSION

This study focussed on the alarming mismatch between health system unpreparedness in SC provision and the exacerbated need for it in times of a public health emergency, such as the COVID-19 outbreak. This study echoes existing recommendations for an all-hazard and whole-of-health approach to disaster planning and management, and has made the case for SC to be included as an important component of any strategic framework for DRM committed to the preservation of quality holistic care.

ACKNOWLEDGEMENTS

We thank all the 25 participants who gave their time during the e-interviews, and all other colleagues and professional in the nursing and spirituality sector who assisted us in the recruitment process. This study was funded by the Burdett Trust for Nursing – Small Grants Programme. Grant ID: SB\ZA\101010662\649037.

CONFLICT OF INTEREST

None. The authors whose names are listed above certify that they have NO affiliations with or involvement in any organisation or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.

ETHICS STATEMENT

Ethical approval for this study was granted by the Middlesex University's Health and Social Care Ethics Sub-Committee (#17428 of 27.4.21). The study conforms to the provisions of the Declaration of Helsinki. Participants provided informed consent.

AUTHOR CONTRIBUTIONS

Irena Papadopoulos: study conception and design; analysis and interpretation of data; critical manuscript revision; final approval of the version to be published; agreed to be accountable for all aspects of the work. Runa Lazzarino: acquisition and interpretation of data; draughting the manuscript; final approval of the version to be published; agreed to be accountable for all aspects of the work. Christina Koulouglioti: acquisition of data; manuscript revision; final approval of the version to be published; agreed to be accountable for all aspects of the work. Sheila Ali: data analysis; manuscript revision; final approval of the version to be published; agreed to be accountable for all aspects of the work. Steve Wright: data analysis; manuscript revision; final approval of the version to be published; agreed to be accountable for all aspects of the work.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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How to cite this article: Papadopoulos I, Lazzarino R, Koulouglioti C, Ali S, Wright S. Towards a national strategy for the provision of spiritual care during major health disasters: a qualitative study. *Int J Health Plann Mgmt*. 2022;37(4):1990-2006. https://doi.org/10.1002/hpm.3443