Exploring the Changing Experiences of Chaplains Employed in Care and Residential Homes During the COVID-19 Pandemic: A Longitudinal Qualitative Study

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Abstract: This article presents an exploration of the changing experiences of six chaplains employed by a large care provider (LCP) during the COVID-19 pandemic. Semi-structured interviews carried out over a ten-month period with six chaplains during the pandemic highlighted three key themes relating to their experiences in care homes during the crisis: (i) adapting work practices; (ii) mental health and well-being; (iii) giving and receiving support. In the context of a worldwide pandemic, this study

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highlights the issues experienced by chaplains in residential and aged care homes at the epicentre of COVID-19-related deaths in the United Kingdom.

**Keywords:** Chaplaincy, COVID-19, care homes

### Introduction

On 23 March 2020, the UK government issued the instruction that people “must stay at home” and described COVID-19 as a national emergency (Tan et al., 2020). Exemptions to the requirement to remain at home included places of work where it was essential to be present, such as hospitals and care homes. While much of the early focus of the UK response to COVID-19 was on the National Health Service (NHS), care homes began to emerge as sites of significant illness and excess mortality (Office for Health Improvement and Disparities, 2022). At the start of March 2020, one large care provider (LCP) operated 90 care homes and over 70 retirement living schemes in England, Scotland and Wales with 4,500 residents. In March 2020, the LCP employed 140 part-time chaplains, which is the equivalent of 54 full-time chaplains, as part of a workforce of 7,500 members of staff.

The most critical phase of the United Kingdom’s experience of the COVID-19 pandemic came in the second half of April 2020. A small number of LCP care homes were affected very severely, with containment measures inside the homes appearing to have only limited impact on the spread of the virus once it was established. One manager described it at the time as a “wildfire” (personal communication to one of the authors of this article, May 2020). By the beginning of June 2020, the LCP had reported COVID-19-related deaths of 413 residents and three staff members (Ashworth, 2020). At times, more than 20 deaths per day were being reported, in a setting where – before 2020 – the average length of stay in the LCP’s care homes was 30 months. As LCP employees, chaplains continued to attend the homes, although 20% of chaplains were over the age of 70 and were obliged to shield at home. Other chaplains had medical conditions which also required isolation. As events unfolded, it was recognized that important experiences were going unrecorded, and that they might be viewed differently at the end of the crisis. Using resources made available from the LCP, it was decided to invite a carefully selected sample of six chaplains to be interviewed about their experiences.
Methods

The combination of two methods were utilized for this study. A convenience sample (Lopez & Whitehead, 2013) is one that is drawn from a source that is conveniently accessible to the researcher. A purposive sample is one whose characteristics are defined for a purpose that is relevant to the study (Andrade, 2021). In this sense, our sample was convenient as the LCP chaplains were accessible to us. It was also purposive in that we chose chaplains in various physical relationships to the practice of chaplaincy during a pandemic; for example, during the first set of interviews, two chaplains were not able to be physically present as they were isolating according to age and health restrictions. This resulted in a sample whose physical reality in relation to their place of work, including their proximity to residents and colleagues, varied greatly. The sample size was small relative to the number of chaplains working for the LCP, which reflects both the individual chaplains' availability to be interviewed, as well as the researcher's available time to conduct the interviews amid a pandemic. Table 1 (Results section) shows the profile of the chaplains and their location in relation to the care homes at the time of the four interviews.

All six chaplains agreed to be interviewed. Ethical approval to conduct the research was granted by the LCP’s Research and Ethics Group. The interviews took place at the end of May 2020 via Zoom, and, with consent, the conversations were recorded for subsequent transcription. As it was felt that the interviews had produced important findings, and given that no immediate resolution of the pandemic was in sight, it was decided that the same six chaplains would be invited to participate in three further rounds of interviews at three-month intervals. This approach offered a longitudinal insight into the experiences of the LCP chaplains across different care homes over a ten-month period. Only one interview was missed, resulting in 23 transcripts over four time points. Only one of the six chaplains was male, no data about ethnicity were collected, and all the chaplains interviewed were Christian. Most of the chaplains were not ordained clergy.

Interviews were audio-recorded and transcribed verbatim, and then analysed using inductive reflexive thematic analysis following the processes set out by Braun and Clarke (2006, 2021). All the interviews were conducted by one researcher (HS, a white British female). Extensive reading was conducted for familiarization with the data before they were coded and the initial themes generated. This was done by another researcher (LS, a white British female experienced in qualitative research). The themes were then reviewed and developed by LS and NJE (a white British female senior
qualitative researcher) to ensure they were data driven. This process allowed for the development of themes that reflected participant opinion.

The approach to analysing the four time points of the interview data followed a recurrent cross-sectional design. All interviews were coded separately in NVivo R1. These codes were then developed from interviews at each time point (resulting in 30–40 broad themes). The themes were then developed across all time points, creating 20 initial overall themes. These were then refined across all time points, resulting in three final themes. The final analysis focused on any differences and similarities between the four time points (Saldaña, 2003).

Results

Table 1 shows the demographic profiles of the participants, gathered through convenience sampling, as well as their location in relation to the care home where they worked, over the course of the interviews.

Three final themes were identified, (i) adapting work practices, (ii) mental health and well-being, and (iii) giving and receiving support (see Figure 1), together with their sub-themes. Each theme was discussed and supported by participant quotations. Quotes were coded to denote participant number and time point of interview (e.g. P1,T1 refers to participant 1, interview time point 1).

Table 1: Participant demographic details

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Participant profile</th>
<th>Location in relation to care home</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Female, white, lay Anglican</td>
<td>Present in care home across all interviews</td>
</tr>
<tr>
<td>P2</td>
<td>Female, white, lay Anglican</td>
<td>Not present in care home during interview 1 – isolating due to health issues; present in home for subsequent interviews</td>
</tr>
<tr>
<td>P3</td>
<td>Female, white, lay Methodist</td>
<td>Present in care home across all interviews</td>
</tr>
<tr>
<td>P4</td>
<td>Female, white, lay Methodist</td>
<td>Not present in care home during interview 1 – isolating due to age; present in home for subsequent interviews</td>
</tr>
<tr>
<td>P5</td>
<td>Male, white, lay Methodist</td>
<td>Present in care home across all interviews</td>
</tr>
<tr>
<td>P6</td>
<td>Female, white, ordained Anglican</td>
<td>Present in care home across all interviews</td>
</tr>
</tbody>
</table>
Adapting Work Practices

This theme relates to how chaplains established new ways of working in care and nursing homes (collectively referred to as “homes” from now on, unless otherwise specified) during the pandemic, and the challenges they encountered. Factors such as the infection rate of COVID-19, safety measures and restrictions introduced to protect staff and residents, and conducting funerals and memorial services are considered in relation to the impact on participants and their working environment.

COVID-19 in the Home

Participants felt that “everything in those early weeks [of the pandemic] was changing … rapidly … [with the] first real impact being closing [homes] to visits” (P1,T1). Most homes were affected by an outbreak of COVID-19 at some point. In the early stages, some experienced an “extensive outbreak that spread very quickly” (P1,T1). Participants reported “exceptional” (P1,T1) numbers of residents dying, which left staff “in deep shock … because we were told in the initial stages that care homes were safe places because they were protected” (P3,T1). There was an acceptance that “we are a nursing home and … we do end of life care” (P1,T2), but participants admitted that although “we are used to losing people … the pace and extent was exceptional” (P3,T4). There were times when participants “got really
upset … [when a] resident had died … [as it] felt that they had been forgotten because the staff had moved on so quickly… to the next crisis” (P3,T1).

Homes not initially affected by COVID-19 believed it was down to “good management and … sensible working practices” (P6,T3). However, there was a “fear that … it might come into the home” (P3,T2), and participants “knew that if the virus got in … the residents would … probably die” (P6,T3). There was “this premise that … it’ll be the carers that bring it in” (P3,T3) to the home, which instilled a sense of “fear” (P1,T2), “terror … [and] background stress” (P5,T2), with staff “doing everything … to mitigate that risk … [as] you feel this weight of responsibility for the residents” (P2,T4). Participants had “bent over backwards in … [their] personal lives not to bring it into the home” (P3,T4), with many participants not seeing their own “parents” (P2,T4) or “grandchildren” (P1,T2).

Role of Chaplains
There were reports of participants “changing their hours significantly … [as] things started to get difficult with the numbers of residents who were dying” (P3,T1). It was felt that “the atmosphere has changed … as there’s so much extra work to do” (P4,T2), and with residents in “isolation in their own room … we [had] to go in and do an activity one-to-one with them” (P4,T2). On occasions, participants had “served lunch and done a tea round but … [had] built pastoral work into that” (P2,T2). Becoming involved in these additional activities with residents sometimes created “an opportunity to connect with people who don’t necessarily want to engage with you as a chaplain because … some people see you as just religious … and keep you at arm’s length because [religion is] not their thing” (P2,T2). This meant that participants were seen by residents as “a human being [rather] … than the chaplain”, enabling them to have “far more chatty conversations … about God” (P4,T4). Relationships with residents deepened, as participants commented that before the pandemic they were not “seeing every resident, every time I went in. Now I … physically see every resident” (P3,T1). It was felt that “one of the crucial things as a chaplain is to build communities … which is even stronger now … with a strong feeling of togetherness” (P5,T1), particularly as “we’ve taken on that mantle of being that family in the home, instead of families being physically able to visit” (P6,T1).

Participants commented that they were “doing a lot more services [themselves] … because there are no visiting church groups coming in” (P1,T2), but due to social restrictions they could not “start mingling” (P6,T2) with the residents, and services were held while trying to “keep people reasonably distant from each other” (P5,T1). As restrictions eased, participants
held “services on individual units … [in] small groups [of] four or five resi-
dents” (P1,T3), which enabled participants to “respond to the people who
have got dementia, as I wouldn’t necessarily say the same things … to people
who have good cognition” (P6,T3). Participants commented: “if for some
reason people can’t come [to services], then I will … do something with
them individually” (P2,T4). There was uncertainty as to whether homes
would “go back to getting everybody together to a big lounge where half
the people can’t hear … [and instead] go for small and intimate” (P6,T4)
groups. However, other participants highlighted “the importance of being
able to worship together” (P2,T4). “From a chaplain's point of view, because
we have been able to continue to minister to our residents … it’s almost like
we’ve been in a cocoon” (P6, T1). It was “such a joy to be here [at the care
home] leading worship … because this is the only space I can enjoy a shared
act of worship” (P2,T3). Participants were “not sure if they would go back to
church” (P2,T4), as they felt:

much more attached to the worship in the home, [as] that’s my main act of wor-
ship now and I feel much more spiritually engaged with the congregation here
than with the church outside … almost don’t feel part of my home church any
more. (P2,T3)

As the pandemic progressed, “the pace of work … eased as we have lost
people” (P1,T3), and considerable time “is being taken up by doing things
that we wouldn’t normally do, for example … Skype calls … with relatives” (P6,T3). Participants also kept in touch with residents’ families “by phone,
by email” (P4,T1) and sending “newsletters … [and] lots of photos of the
activities we were doing” (P1,T1). Some participants used Facebook to post
details of “the activities … [so] families could see what their relative was
doing” (P4,T1). This enabled families to “ring their relative … encouraging
them to join in” (P4,T4). The new methods of communication also meant
families living abroad who “wouldn’t normally have that direct contact
with [residents]” (P1,T2) could keep in touch. They even accommodated
one “family [who] wanted to have end of life prayers by Zoom” (P1,T1).
Participants felt they had “got to know the families far better than I have
before [COVID-19]” (P4,T1) and had “become a virtual family” (P4,T4)
over the duration of the pandemic. They felt it had “really deepened a lot of
relationships” (P3,T2), as they had “been a better chaplain to the families
than … before … [T]he first time I ever met families was at a funeral …
whereas now … I am in touch with every single resident’s family in the
home” (P4,T1).
Participants felt they had “established a new rhythm to our work” (P6,T3), and the role changes highlighted the “multi-layered level to … chaplaincy … to make sure people are not only cared for physically, [but also that] they are stimulated mentally … [and] feeling well in themselves” (P5,T3). It had been “reinforced how important physical presence is … [and] to be able to physically be with people who were so poorly was so moving and important” (P1,T3), but it had “been really difficult being present to people who are in their rooms in isolation” (P6,T3).

For many participants, this had resulted in changes to their “concept of spiritual care … [as] the chaplaincy’s role … has completely changed” (P4,T4), and “the majority of what I have been doing the last few months is supporting families and … staff” (P3,T4), dealing with “bereaved families … funerals … and all those calls we are doing” (P6,T4). Participants felt that these new tasks could not be done within their old job role, and that this breached “rather porous boundaries … [as] it is not possible to do that role within the parameters” (P6,T4). Participants commented: “if I literally just stuck to my hours, I wouldn’t be doing any other ministry, apart from Facetiming and the really important end of life care” (P6,T4). It was felt that the additional workload was “constant … [with] picking up things that aren’t [part of] a chaplaincy role” (P2,T4), but this flexibility left “managers … [who] have been sceptical about chaplaincy … seeing it in a different light” (P5,T1).

Safety Measures

The extent of safety measures put in place impacted the participants, who found it “quite wearing, putting on and [taking] off PPE all day” (P6,T4). As restrictions were lifted, there was a sense of “uneasiness” (P2,T3) about the return of indoor visits, and it created “a real angst for a lot of staff … because families are going to be coming in, then the figures [COVID-19 infection rates] are going to go through the roof” (P3,T4). Participants were aware that staff felt this “pressure to keep people alive … [and] have picked up more anxiety about visits coming back than … about the lack of visits” (P1,T2). It was seen as “an absolute nightmare … we have spent the whole year in this little closed community … paranoid at keeping [residents] as safe as we can, to suddenly get the idea that somebody else can come in has become disturbing” (P5,T4).

Although it “was an absolutely wonderful moment” (P5,T4) when the first COVID-19 vaccinations were administered, it created “a false mood” (P4,T4). It did not “make any difference to what we can and can’t do and … [it] has possibly created some frustration for … residents and … relatives
... they’ve had [the vaccination] weeks ago now, [so] why are we still facing the same level of restriction?” (P1,T4). Most staff “have all been vaccinated, a couple of them haven’t” (P5,T4); “particularly ones that want to be having babies in their future … are a bit anxious about having it done” (P3,T4). (On 11 November 2021, legislation came into effect making the vaccination of staff in care homes a condition of deployment in resident-facing roles.) In some cases, participants found themselves “counselling a few young staff who are yet to start families who are feeling really badgered and bullied and upset that people weren’t understanding their reluctance” (P2,T4). Having received the vaccination “feels like we’ve got some form of protection” (P5,T4), and “some of us feel less anxious … [and] maybe that is one of the differences the vaccine will make, it does feel safer to start looking back in a way that it is not all going to start again” (P1,T4). “At the end of the day we are all doing all we can to protect ourselves, so by protecting ourselves we are protecting [residents]” (P5,T1) “and that’s the most important thing” (P6,T3).

Funerals and Memorial Services
At the height of the pandemic, one participant commented, “the big change … was that there were lots of funerals … [O]ne week … I did five, another week … I did four” (P1,T1). With restrictions in place, participants felt opportunities to conduct funerals were “limited, but people have really appreciated having a minister who knew their relative … to have taken a service for them in those circumstances” (P1,T1). There were emotional reports of a grieving family member having to “sit on his own, because he lives on his own … he was so upset and no one could go and give him a hug … it’s the only time ever, I … had a little cry” (P1,T1) after a funeral service. The “lack of the ability to stand close to someone or give them a hug … was a bit of shock … it is a bit of challenge” (P1,T4). As restrictions lifted, it was felt:

[the] worst thing about … funerals at the moment is leading … to a chapel full of people in masks … [It’s] so hard because normally you … adapt as you go, depending on how people are reacting, and when everyone’s got a face mask on, it’s actually really difficult. (P1,T4)

In normal times, homes “have had a memorial service … every year for the families who have [relatives who] died in the previous year” (P4,T4), but participants were “not going to be able to … this year because we can’t … invite the families” (P3,T2). Participants “have found ways round the lock-down which have been quite creative” (P5,T1), and held memorial services
by “privately remembering them and putting their names on butterflies … [to] hang on the tree … [and] sending a card [to families] to say they were remembered at All Souls” (P2,T3). Others “knitted hearts … [for] every resident and … had stones … [and] people poured out their pain into those stones” (P3,T4). Other homes had managed to hold memorial services with “family groups together” (P6,T3).

**Mental Health and Well-Being**

This theme examines the impact of the pandemic on the mental health and well-being of participants working in homes, and the strategies they embraced to cope with the pandemic and the enforced restrictions.

**Mental Health and Physical Effect**

Participants explained there had “been a heightened level of anxiety” (P2,T2) throughout the pandemic, with a “huge amount of conflicting … emotions” (P3,T2), including feeling “weird, lost, alone, bereaved, [and] really sad” (P3,T2). Participants were “absolutely shattered” (P5,T3) with “the pace of work … [and] there were times when it was really exhausting” (P1,T3), with participants saying they felt “petrified … nervous … and … anxious” (P3,T3). It felt like “there is a background tension that is starting to wear … [as] you are constantly on alert” (P5,T3).

Participants were left feeling like they were a “different person … [and] shouldn’t ever be happy again” (P3,T2) “because of what we have experienced” (P3,T3). There were reports of participants feeling “not quite as confident in myself as I have been” (P2,T2), going “from the height of massive privilege … to … a disbelief … [of] did it actually happen” (P3,T2). They felt their “mental health has suffered … there is definitely post-traumatic stress … [and] if it didn’t come out in tears it would come out in some other way … like panic … or anxiety attacks and physical illnesses” (P3,T3). There was a belief that “damage … has been done to … mental health because you can’t do what you instinctively feel you need to do … the idea of moral injury is part of the PTSD” (P3,T3).

However, there was also a sense of privilege “to be alongside people when so many of them are … vulnerable … distressed and … tearful” (P3,T1). Some participants reported that their experience of the pandemic “makes me feel that I am now where God wants me to be and I really feel now I am a round peg in a round hole” (P3,T3), and “it has been one of the most faith deepening and faith building experiences of my whole life” (P5,T4). Yet others were “very aware … that as a priest … it has pushed me off centre …
away from the centre that is God to a more egotistical centre that is not of God” (P6,T3).

Coping Strategies
Participants had different ways of coping with the impact of the pandemic on their own mental health. It was important for them to recognize that “you’re not just helping all the staff, residents and families … you’ve got your own grief to deal with as well” (P3,T2). They felt that:

as horrendous … as traumatic as it was, life does move on and you do have to come to terms with what has happened and carry on … [otherwise] you get to the point that you can’t be happy or you can’t laugh any more because it’s being disrespectful. (P3,T2)

Participants coped by “pampering” (P3,T2) themselves and doing “things that gave me a lot of pleasure” (P3,T2), such as “going for a walk” (P5,T3) or engaging with “nature … [and] craft work” (P3,T3). Others found “prayer has been really helpful … and having a sense of purpose … and a sense of value” (P1,T3). It was important for participants to give themselves “space and permission to deal with that [emotion] in a safe place” (P1,T3) and “try and get that balance back” (P3,T3), by “reminding myself to step back and take time and think” (P5,T3), “to take a breath” (P1,T3) and “to take time for myself” (P6,T3). On self-reflection, participants had learned “that I’m more resilient … [and] more adaptable than I thought I was” (P5,T3), and that “these times do lend themselves to greater theological reflection … sometimes we are so immersed in the realities and the practicalities of everything, that we don’t do that” (P6,T3).

Some found that from a “spiritual point of view … it’s sent me back to some reading … [about] trying desperately to find God in whatever situation … actually, God is in there, all you need to do is find Him” (P5,T3). Others commented that the “experience of being a chaplain in older age care in the pandemic has demonstrated more fully than anything else has before that complete and utter reliance on God” (P5,T4). Coping through the pandemic has “certainly confirmed the call I believe God gave me … because if it weren’t real and if it wasn’t God who had put me here and equipped me to do it, then that would have rapidly become clear” (P5,T4).

Giving and Receiving Support
This theme considers the need for support during the pandemic; the emotional support that participants offered to staff within the homes, and the
emotional and physical support the participants experienced during the pandemic.

**Supporting Staff**

Participants commented that “it was an absolute shock for everybody … when we were all beginning to see people die … then it was increasingly about supporting the staff … they really have gone through the most horrendous, traumatic time” (P3,T1). Participants were “trying to support staff who are really struggling … [and] chaplains were in a very privileged and unique position … to provide … help and support” (P3,T3). Due to the number of residents dying, participants found themselves asking general questions, such as “how are you coping with the volume of loss as opposed to how are you coping losing this particular resident?” (P1,T1). “Generally speaking, the staff … have been absolutely relieved that there has been that … ongoing friendly face that’s been there far more than normal” (P6,T1), and they “have been talking to me about their own fears and concerns” (P2,T2), with “more staff asking me to pray about things than there ever was before” (P4,T2).

It was felt that “to be alongside the staff whilst they were so traumatized has been a massive privilege … [which] speaks of the value of chaplaincy … [as it has created] a deeper relationship with the staff” (P3,T2). Conversely, in some homes, participants felt there “is almost … peer pressure on some people to not talk about it … reflect on it or dwell on it” (P1,T2), and they experienced that:

> [only] a small number of staff … actively seek me out for support … having someone that is not seen as specifically from [a] chaplain or religious background might be helpful for some of those … or it may just be that genuinely they want to look to the future. (P1,T2)

**Support Received**

Participants received support from a variety of sources. They felt that the “regional chaplain and head of chaplaincy” (P2,T1) had given “really outstanding support” (P1,T2). At the same time, faced with uncertainty about the duration of the pandemic, the LCP made changes in several areas of central support. This included a restructuring of the chaplaincy adviser role that related most closely to chaplains in homes. This led to the departure of existing advisers, which left participants feeling “traumatized” (P3,T2), as “what has suddenly disappeared is emotional and professional support …
from someone who knows who I am, knows what the circumstances are, who understands the mechanics of doing the job itself” (P5,T2). It was felt that “the timing is atrocious” (P5,T2) and left participants feeling “out on a limb … [as] by no means is this over … there are still challenges, there are still difficulties … and you … take away the support now” (P5,T2).

Some participants said that the regional advisers and heads of chaplaincy had “kept us all connected” (P4,T1) by offering “counselling … sessions with other chaplains … [and to] have that opportunity to talk … and get their perspective … made a huge amount of difference” (P3,T2) and gave a “sense of being together with other chaplains” (P1,T3). Some participants had a “spiritual director outside of work” (P1,T2) who was “supportive” (P6,T2) and would also “organize pastoral support … to talk to other chaplains” (P3,T3).

Participants also attributed “a huge amount to the staff” (P3,T4); “there is support … in abundance, within the home” (P5,T4), with “staff members … who have been very supportive” (P2,T3) and colleagues being “each other’s sounding board” (P6,T4). Participants reported that colleagues provided some practical support with delivering acts of worship, “which does take some of the pressure off … [as] I know they [the residents] are getting their faith … that they need. It frees me up for … general support for the staff and families” (P3,T3). Participants thought it was:

[r]emarkable … that this team of people really are just so ultra-professional and we draw strength from each other … [I] would have found this so much more difficult if I wasn’t privileged enough to work in a place like this … we do look out for each other and support each other. (P5,T3)

Other practical support was missing, however, as chaplaincy volunteers were not allowed in the homes under the restrictions, and participants commented that these “key people with a key role … could be absolute gems and [would] be so helpful for us at the moment”, and there was a worry “that when all of this [is over] … we may lose some volunteers … [and it has] taken us years to develop that network” (P6,T2).

Some support came “from family and friends” (P2,T2), but some found it difficult to open up, as participants went through a “phase of thinking what’s the point in talking about it because … nobody else understands and the only people that understand are … the carers that I was working with in the home at the time” (P3,T2). Participants did not like to “talk to everybody about how hard it is because it’s tough enough having to deal with it when you’re having to deal with it at work” (P2,T2). This feeling was “likened … to the soldiers in the war; when they came back from the war
they never talked about their experiences because … only their colleagues understood” (P3,T2).

**Discussion**

The impacts of the COVID-19 pandemic are multiple and can range across almost all aspects of an individual’s personal and professional life. This ubiquity is evidenced throughout the interviews. There appears to be little in life which has been left untouched. Because the data were gathered from participants connected to care homes, they offer a unique insight into the work and thoughts of people in those institutions, which, collectively, experienced “the greatest relative increase for any recorded place of death” in the United Kingdom (Jones, Taylor & Clement-Rees, 2022, p. 3).

The work of chaplaincy was transformed in some homes due to periods of significantly increased mortality. As a consequence, participants often ended up conducting far more funerals than would normally be the case. Participants found this to be both a privilege, as in all cases they knew the deceased, but also an emotionally moving experience. This was especially the case because of the limitations on the number of mourners and the social distancing rules that applied. Like Queen Elizabeth at the funeral of her husband, the sight of grieving and isolated individuals added to the trauma of loss (Lloyd, 2022). In many respects, consolation was precluded. From the interviews, it was clear that participants were affected by this experience.

A core characteristic of chaplaincy is flexibility (Adams, 2019). In care settings, chaplains rarely operate exactly as they would in more normative religious spaces, such as a mosque or church. Adaptation to the circumstances of care requires inventiveness and the capacity to translate traditional approaches and expressions of spirituality in ways that make a meaningful connection (Drummond & Carey, 2020; Vandenhoeck et al., 2021). Research undertaken on chaplains’ journals during the pandemic in hospitals in the United States (Desjardins et al., 2022) echoes the findings of this study that chaplains demonstrated considerable creativity in delivering their role during the crisis. In particular, this was evidenced in the remote support for relatives and residents through phone or Zoom calls (Snowden, 2021).

It is important to note that remote communication was well established in care homes prior to COVID-19, including recognizing the significance of cards and letters (Hindle, 2022). While the emerging literature about spiritual care during COVID-19 evidences some dissatisfaction with virtual communication (Edelman et al., 2021), our findings show that there
were benefits to this experience, for example, a stronger sense of connection between the chaplain and the relatives of residents (Swift, 2020). Given the burden of restrictions on visiting during the pandemic, the links created via the chaplain were seen as both valuable and beneficial. This picture became less positive when it came to changes in regulations within the homes (e.g. the easing of visiting restrictions). This easing caused great apprehension for some members of the LPC staff. After a long period of isolation, there was a fear that visitors might bring COVID-19 into the home. It is important not to retrospectively underestimate this experience, at a time when the course and consequence of the pandemic was unknown.

Participants became more flexible in their working hours and often worked more than their contract required. In an attempt to ease pressures in the home, chaplains also carried out additional duties (Best, Rajaee & Vandenhoeck, 2021), such as taking round refreshments and meals. This was seen in a positive light when it mediated interactions with residents who were less likely to access chaplaincy during normal circumstances. In essence, it was seen to “humanize” the chaplain. During the most severe social distancing, participants were doing more one-to-one work with people and, as restrictions eased, acts of worship began to take place with small numbers of residents. This enabled chaplains to further develop one of their central roles in fostering and facilitating a sense of community (Mowat & Swinton, 2005).

During the health emergency, the use of personal protective equipment (PPE) gradually increased. Initially, perhaps due to concerns about supply (Hanna et al., 2022), care homes were only required to use PPE universally if there was an outbreak of COVID-19 (Harrison & Scarle, 2020). However, this changed over time and reached the point where everyone working or visiting in a care home was obliged to wear at least a mask. As participants stated, this was not a pleasant addition to people’s working day, and it created challenges in communicating with residents. However, feelings about the continuous use of PPE sat alongside anxieties once external visiting resumed. For people working in homes that had felt sealed and safe, this exposure to a wider community caused unease (Altintas et al., 2022).

The degree of uncertainty about the course of the pandemic, and the risks associated with the virus, engendered a widespread sense of anxiety. This was felt by the participants, several of whom noted its presence and influence. Being on “ready alert” for extended periods of time, not knowing what would follow an initial report of infection, left chaplains feeling exhausted, sad and lost. Khosa-Nkatini (2022) commented on challenges to mental health for clergy during the pandemic (Jones et al., 2022). A primary step in achieving support is the recognition of personal suffering and need,
and the willingness to voice this and reach out for assistance. The interviews demonstrated that participants were willing to discuss their experiences and name moments of vulnerability and emotional cost. At present, it is unclear how many chaplains or other care staff operating in the United Kingdom have been offered a similar opportunity to narrate their experience of COVID-19 (Kwak et al., 2022).

While the pandemic was an unprecedented health emergency in the lifetimes of the participants, previous work has examined the impact of events during more localized catastrophes. Trauma theology is a field of study which is relatively new, with Rambo’s landmark title appearing in 2010. Significantly, while paying attention to the active phase of an event such as Hurricane Katrina, Rambo is also keen to focus on the aftermath, when the spotlight is no longer on the community which has borne much of the brunt of the crisis. This is described as the “Holy Saturday” experience, between acute suffering and any subsequent recovery/resurrection. In the context of COVID-19, it suggests that continuing support may be less visible (or less prioritized) but still needed, as people recover from the traumas they have experienced. As many of the interviews suggest that at times chaplains felt overwhelmed, it is also of interest to consider the theological work done on this by Slee (2020).

There may also be correspondence between the findings of this research and the growing field of “moral injury” (Davies, 2023; Frame, 2015), which includes “failing to prevent, bearing witness to, or learning about, acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009). People were kept apart during the pandemic for good reason, and chaplains were part of the culture of social distancing, which denied or altered normal channels of consolation and comfort (e.g. at funerals). There is evidence from the research data that the pace of deaths and funerals diminished the normal rituals of acknowledging deaths and enabling people to participate in these if they wished. At the same time, chaplains spoke about the fears common to all colleagues working in social care, that they might become a source of transmission for the virus, which could have devastating consequences.

Support for participants came in a number of forms, from family and friends to colleagues in the homes. The interviewees stated with regret – and some anger – that the LCP Chaplaincy Directorate had made changes to its central support structure, leading to the loss of the regional chaplaincy advisers. As these individuals had long-standing relationships with many chaplains, this change was experienced negatively. Like many organizations, loss of income from residents’ fees and steep rises in the price of PPE – although offset to some extent by government aid – led many providers to
review their central costs and ways of working (Daly, 2020). An opportunity to review the way organizations manage both personnel support and central restructuring during the course of a health crisis may be beneficial for the future.

**Strengths**

Since building and sustaining relationships is a central tool in the practice of chaplaincy, the research approach allowed for valuable insights to be gathered due to the relational nature of the interviews. The format of the data collection was therefore congruent with the characteristics of spiritual care. An at-a-distance approach, via Zoom, reflected the increased use of remote forms of communication during the crisis, and acted as a strength, as it allowed chaplains who were isolating to both express and reflect on their feelings, as well as avoid unnecessary contact, as per the restrictions at the time. In addition, the analysis of the data was outsourced to researchers who did not work for the LCP. These researchers were experienced in a number of qualitative methodologies, which avoided potential biases.

**Limitations**

One of the key limitations of this research is the sample size. Although it is clear why this sample size was chosen, future research could benefit from a larger sample size. Also, the sample was also both convenience and purposive, so the external validity is limited by the restrictions of these methods of sampling (i.e., generalization is possible only to the population from which the sample was drawn, and to those in the population who have the characteristics of the sample studied; the findings therefore cannot be generalized to a broader population. Additionally, in future research it would be important to consider in advance how to conduct research during a health emergency leading to prolonged periods of isolation, as this was not given prior consideration. It is also important to note that although the participants’ profile represent the general profiles of chaplaincy at this LCP, the chaplains interviewed represent a lack of diversity when compared with broader demographic information on gender, religious beliefs and ethnicity.

**Conclusion**

These 23 contemporaneous interviews conducted with chaplains between May 2020 and February 2021 have captured evidence about life in care
homes during COVID-19. In particular, we hear in the voices of the chaplains the anxieties of people working in places of care that became the epicentre of COVID-19-related deaths. The interviews demonstrate the inventiveness and commitment of chaplains as they adapted their roles to the changing regimes of movement and contact during the various phases of the pandemic. Some of the interviews suggest that during the lockdowns chaplains extended the scope and quality of their relationships with residents, relatives and colleagues. Central to this was the humanity of the chaplains and their presence in a shared context of crisis, in which they shared the fears and anxieties of the people around them.

One issue identified during the research, and supported by the literature (Riello et al., 2020), concerns the ongoing support for people who experienced some of the worst manifestations of COVID-19. It can be argued that the subsequent crises affecting the context of social care, such as the high cost of living and inflation, have partly arisen from the pandemic, despite other factors also being involved. The succession of events which have followed the acute stage of the pandemic may therefore have made it more difficult for chaplains to access the support they need. It would be helpful if further research could explore the longer-term impacts of the pandemic on chaplains working in care homes.

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