COVID-19 PANDEMIC

UK Chaplaincy Associations Response

Abstract

UK wide chaplaincy associations have put together a joint response and suggested guidelines for all chaplains. Together with the NIHCA guidelines, issued to membership on 16th March, this document may be helpful for Chaplaincy managers across all our Trusts.

From the UK Board of Healthcare Chaplains (UKBHC), Northern Ireland Healthcare Chaplains Association (NIHCA), College of Health Care Chaplains (CHCC), and Association of Hospice and Palliative Care Chaplains (AHPPC) – 17th March 2020

At present, our focus, and the focus of Chaplaincy Managers across the UK is to balance the care and safety of patients/staff with our duty of care to our chaplaincy teams. We have therefore issued the following statement jointly with the professional bodies. We expect individual bodies may also issue their own guidance in coming weeks as we navigate through the new territory we find ourselves in. As national plans move into 'social isolation', we recognise how countercultural this can feel for Chaplains, given how much we all work towards social action and community. We recognise that all teams are developing local plans and there is no single one size fits all response, but we hope the following guidance may be helpful.

The UKBHC, NIHCA, CHCC and AHPPC recognise that those working within Chaplaincy face specific challenges with Covid-19 due to the very nature of our profession:

A) We have many small teams and single-handed Chaplains already dealing with a challenging workload, now faced with an unprecedented change in demand and models of working.
B) Many working in chaplaincy have dual responsibilities with competing demands at present.
C) A disproportionately high percentage of healthcare Chaplains may fall into the higher-risk categories.
D) The level of risk to exposure in healthcare settings it always going to be higher than for the general population.
E) We are expecting a significant increase in demand for acute and end of life care.
F) We are expecting a significant increase in demand for staff support.

In the light of these, we are suggesting the following broad measures that may be considered in the coming days:

Urgently freeing up capacity

Review services with a view to stopping non-core services (e.g. 1:1 Bereavement Support, Community Engagement, CCL, teaching, community / home visits).
It will be important to significantly revise the criteria for referral and response to ensure capacity is not overloaded.
We should not be going bed to bed in any role.
We may need to clarify what is an appropriate 'urgent referral only model' for our situation.
We expect that volunteer visiting and any existing worship services are likely to be suspended if this has not already happened.

Temporary changes to On-call

This will depend on the capacity of teams and how that changes when team members become infected, or if those at high risk move into isolation in the coming week.
There may be an exceptional role to play for honorary chaplains and chaplaincy volunteers (who would not normally be part of any on-call system) if have the right experience and are Fit to Practice in those key areas during the critical phase.
Smaller teams may chose not to retain 24/7 on-call services, may need to change to a simple cascade system or reduced cover- (e.g. stopping at 10pm) in order to reduce burnout.)
Changes need planning in the next few days before they are required.

Significantly different patterns of working

Different models of care may be required for patients who are Covid-19 positive- and all team members will need to be well informed of safe practice as guidance changes almost daily.
We need to think clearly in advance about how any changes in chaplaincy support to patients is **communicated sensitively** to staff, patients and relatives, e.g. if a Chaplain is not permitted to attend in person- how do we gently say so?
Alongside operating on (or near) a major Incident footing for a sustained period of time in the coming weeks, we need to consider how we will maintain support and respond to other critical incidents such as trauma and pregnancy loss.
It is critical that teams work very closely with the senior management to agree what support we offer and what we can't. This may be particularly important in specialist units (such as Hospice settings).
In some areas it may be possible to work collaboratively with neighbouring teams or merging distinctive faith/belief on call rotas.
Much support may need to be by phone/video rather than in person.
We may need to proactively engage with local faith/belief groups, advising them on best practice and potentially working more closely with them to enable support for patients (retaining the need to ensure that they are experienced and competent to practice)
Flexible changes to working patterns may be inevitable. It may work better, for instance, to change to X days on / X days off for some teams for a period. Any model adopted has to work well for all staff concerned.
It may be decided for some that a 7 day working week will better provide visible support to staff - with shorter shifts required daily.
It may be that many of all staff will, at some point, be working from home, and resources for this will need planning in advance. Do all team members have what they need to work from home, admin, telephone support, relevant contact details?
Review the use of Chapel/sacred space in terms of staff support and space for grieving, including all infection control issues.
Whatever models we put in place, we must allow for decent “rest periods” for the Chaplains involved. Teams will be carrying a great deal of emotional distress of others and their own. We must therefore pay particular attention to self-care and team care, especially as this outbreak may last for several months.
Review communication within the team – e.g. establish a daily telephone conference call?

Enhanced focus on staff

During the critical phase we will need to target most of our response / areas of work and limited resources at staff support.
Such work will require creativity- can we offer telephone support to staff in a way that is harmonised with Occupational Health?
We may consider strengthening 'named/link chaplains' to be assigned to critical areas or teams (ED, AMU, ICU, respiratory wards) for regular check-in with staff, understanding local pressures and building relationships.
We may further enhance visible 'walk-arounds'.
We need to consider our suitability for redeployment as requested- balanced with what we are planning to offer as a team.
Staff colleagues will be working under enormous stress with professional (and indeed ethical) challenges. They are also parents, and children and partners and they will be worried about their own loved ones.
We need to ensure senior managers are aware of evolving plans we have in place and our revised focus.

The most important point is to plan now and make communications robust in the coming days.

We recognise that much of this is obvious- but we would strongly encourage teams and individuals to be proactive – making plans and contacting neighbouring Teams to share ideas. Some senior health leaders may not fully understand all that we do, or could do, so we must be creative in discovering and communicating how we best support staff and patients at this time, whilst also looking after our teams and ourselves.

With warmest regards,

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