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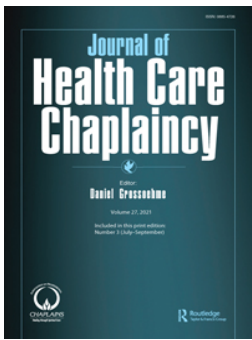
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A beacon in the storm: competencies of healthcare chaplains in the accident and emergency department

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ABSTRACT

Introduction: In several Dutch hospitals, healthcare chaplains provide care to accompanying persons at the accident and emergency (A&E) department, even though they have not been trained for such a dynamic, high-intensity environment. We therefore examined the competencies they feel they need in this setting.

Methods: Interviews were conducted with 14 healthcare chaplains from nine hospitals, and with five A&E nurses from two hospitals.

Results: All respondents considered healthcare chaplaincy essential in the A&E department. Our findings support the need for psychosocial and communicative skills, knowledge of mourning processes, flexibility, sensitivity, and reflexivity. Additional competencies included sensitivity to existential concerns, practicing presence, a person-centered approach, medical knowledge, and letting go of a solution-oriented approach.

Discussion: The chaplains questioned the sufficiency of their leadership skills, pragmatism, and medical knowledge. To ensure their sustained availability for people in crisis, more systematic efforts are needed with regard to aftercare, evaluation, and self-care on the part of healthcare chaplains.

Introduction

In several Dutch hospitals, healthcare chaplains have been charged with caring for accompanying persons in the accident and emergency (A&E) department. These care professionals seem well-suited to this task, because they possess many of the competences that are needed in this situation. In addition, they are able to make themselves fully available to the accompanying persons, unlike nurses, who also have patient-care duties. The efforts of healthcare chaplains seem to have a positive impact on care. For example, one Dutch hospital has received a five-star rating for hospitality due to its practice of charging healthcare chaplains with caring for accompanying persons in the A&E (Gastvrijheidszorg met Sterren [Hospitality care with stars], 2016).[1] At another Dutch hospital, members of the medical staff attributed improvements in patient satisfaction in

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the A&E to the assignment of healthcare chaplains to the care for accompanying persons (personal communication, June 28, 2016). As observed in a recent review of studies on spiritual care in intensive care units (ICUs), both patients and family members report greater satisfaction with care after having received spiritual care. This type of care has also been associated with a higher quality of life and less aggressive care at the end of life (Ho, Nguyen, Lopes, Ezeji-Okoye, & Kuschner, 2018).

However, healthcare chaplains in the Netherlands are not trained to provide care in the dynamic, high-intensity environments of A&E departments. This could influence not only the quality of the care that they provide, but also the well-being of the healthcare chaplains themselves. In this study, therefore, we examine the experiences of healthcare chaplains working in Dutch A&E departments. The research question is: What competencies do healthcare chaplains feel that they need in order to provide care for accompanying persons in A&E departments?

Background

In an A&E, children and adults receive medical and nursing care for critical injuries, life-threatening conditions, and urgent problems that cannot wait until a general practitioner is available. The A&E is an environment characterized by many rooms, extensive medical equipment, and many different care professionals. The unplanned arrival of patients, the intensity of care, the short duration of the stay, and the presence of permanent staff members who are constantly on the move and incoming specialists from various other departments in the hospital combine to create the dynamic environment of this department. The family, friends, colleagues, and neighbors who accompany patients are thrust in the midst of such "hustle and bustle."

Attention to the needs of these accompanying persons in the A&E is of considerable importance. Particularly in life-threatening situations, those accompanying the patients are actively involved in the care process, due to their unique knowledge about and relationship to the patients (Boudreaux, Francis, & Loyacano, 2002; Egging et al., 2009; Ekwall, Gerdtz, & Manias, 2008, 2009; Hallgrimsdottir, 2000; Redley, LeVasseur, Peters, & Bethune, 2003; Twibell, Craig, Siela, Simmonds, & Thomas, 2015). However, the—often sudden—prospect of the patient's death can have severe emotional consequences for an accompanying person, ranging from shock to grief and from anger to guilt (Allen, 2005; Davies, 1997; Kübler-Ross, 1969; Tye, 1993). If these people have no opportunity to arrive at understanding and closure with regard to the situation, a sudden loss can even develop into psychological trauma, especially when the death involves complicating factors such as the belief that the loss could have been avoided, violence, children, or a complicated relationship between the person and the deceased (Davies, 1997). Probst, Gustin, Goodman, Lorenz, and Wells-Di Gregorio (2016) reported that about 40% of 121 family members who had experienced the death of a loved one in a hospital within the past year met the diagnostic criteria for complicated grief disorder. There was no difference between family members of patients who had died in the ICU and those of patients who had died in other hospital departments. The family members of patients who had died in the ICU indicated that the most distressing experiences

were not being able to say "goodbye," witnessing resuscitation efforts, and seeing the loved one experiencing fear of death or dying.

The needs of accompanying persons in critical-care settings such as the A&E have been investigated in several studies (Dückers & Rooze, 2011; Dykstra, 1990; Hallgrimsdottir, 2000; Leske, 1986; Redley et al., 2003; Redley & Beanland, 2004). These studies clearly demonstrate that a distinction can be made between needs relating to the following aspects:

- Communication, which is central and concerns not only the exchange of information, but also the importance of experiencing an emotional connection between the accompanying person and the care professional, as well as the availability of the care professional
- Meaning, which includes a need for understanding, significance, and religious practices
- Proximity, which is essential for reassurance and reaching closure, particularly during resuscitation and after death
- Comfort, which encompasses needs for physical self-care and emotional comfort
- Support, which concerns the social context (presence of other accompanying persons), the importance of presence (undivided and non-judgmental attention) of the care professional, and the importance of guidance by the care professional. Presence is known to enhance feelings of relief and trust on the part of patients, and the development of new coping strategies (Derksen et al., 2017).

The provision of care to accompanying persons in the A&E thus requires specific competencies on the part of the care provider. Several authors have stressed the importance of psychosocial and communicative skills, knowledge of mourning processes, flexibility, sensitivity, personal and professional reflexivity, and fast and continued availability (Davies, 1997; Dimond, 1995; Redley et al., 2003; Tye, 1996). The required combination of skills and the high emotionality of the situation make the provision of care to accompanying persons in the A&E a demanding task (Hallgrimsdottir, 2000).

Although some descriptions of the experiences of healthcare chaplains in the ICU (Choi, Curlin, & Cox, 2015) and critical-care units (Hughes, Whitmer, & Hurst, 2007) exist, most are based on case studies. To the best of our knowledge, this is the first systematic investigation into the experiences of healthcare chaplains in the A&E.

Methods

Participants

From March to June 2016, a qualitative, cross-sectional study was performed among healthcare chaplains in nine hospitals located throughout the Netherlands. The hospitals were selected through purposive sampling, to ensure the representation of various types of hospitals and the selection of hospitals in which healthcare chaplains had been or were still involved in providing care in the A&E. The final sample consisted of three general hospitals, three top-clinical hospitals, and three academic hospitals. To become acquainted with the environment of the A&E and its demands, the researcher (RP) was given a guided tour of one of the hospitals, and conducted an 8-h observation in another hospital. In the nine

participating hospitals, the knowledgeable healthcare chaplain in the team was invited for a telephone interview concerning the nature of the care provided in the A&E. In addition, face-to-face interviews were conducted with 10 healthcare chaplains from the five hospitals that still maintained active assignment to the A&E. To examine how other care professionals experienced the presence of healthcare chaplains in the A&E, interviews were conducted with five A&E nurses from two hospitals. The average age of the healthcare chaplains was 52 years, with an average of 10 years of experience working in the A&E. Four of the chaplains were male. The average age of the nurses was 34 years, with an average of eight years of experience working in the A&E department. All of the nurses were female.

Interviews

Face-to-face semi-structured interviews were conducted at the respondents' workstations. Participants were invited for the interviews by email, and they were asked to provide written informed consent. The interviews focused on the organization of care, notification, role fulfillment and positioning, competencies, needs of the accompanying persons, relationships to other care professionals, the role of meaning making, aftercare, evaluation, and self-care. The interview guide is provided in Appendix A. Respondents were encouraged to refer to real-life cases to illustrate and clarify their answers. The duration of the interviews with the healthcare chaplains was about 90 min, and the interviews with the nurses lasted between 45 and 60 min. The interviews with the nurses were shorter, because they had more difficulty reflecting on the care provided by healthcare chaplains. This was because they were not closely involved in the provision of such care, and it was only one of the aspects of the integrated care that they provided.

The interviews were conducted by a trained Master's student in spiritual care (RP), within the context of an internship and a Master's thesis project. After the interviews, respondents were offered a brief summary of the telephone and/or face-to-face interview, to which they could respond and suggest corrections. In general, the respondents felt that they had been understood, and there was little need for corrections.

Data analysis

Audio recordings were made of all interviews, which were transcribed verbatim. Thematic analysis was performed by RP, under the guidance of WS and AV. Themes and categories were derived from the existing literature on the needs of accompanying persons as described in the Introduction section (deductive analysis) and from the interview data (inductive analysis). This resulted in the coding scheme displayed in Table 1. For the sake of readability, headings that were not part of the coding scheme were added in the Results section.

Results

Availability

The availability of healthcare chaplains in the A&E departments varied widely. At the time of the study, only two hospitals had structurally assigned the healthcare chaplains to the A&E. These structural assignments were the result of positive experiences that

Table 1. Final coding scheme for needs and competencies relating to the provision of care by healthcare chaplains to accompanying persons in the hospital accident and emergency department.

Themes and categories
Availability
Responses of accompanying persons
Needs of accompanying persons
Understanding
Significance
Rituals
Proximity at resuscitation
Proximity after death
Information
Connection
Self-care on the part of the accompanying person
Social network
Presence
Guidance
Organization of care
Aftercare
Evaluation

chaplains and staff members had reported with regard to previous incidental calls and pilot projects. In four other hospitals, the healthcare chaplains were available only by request, due to limited capacity. In the three remaining hospitals, a pilot project had been conducted and was under evaluation. Depending on whether calls to healthcare chaplains were based on the personal judgment of the A&E nurse, on a general guideline for indicated situations (such as, when the patient is a child or for "high-impact" situations), or on a protocol, the number of calls ranged from three per year to four per week. If specified in a protocol, a healthcare chaplain was called whenever a patient needed to be resuscitated.

Managing job demands

In many hospitals, healthcare chaplains are on call for 24-h shifts, and the respondents considered this important to the quality of care in the A&E. In addition, healthcare chaplains could stay as long as needed, a feature that distinguishes them from other professionals who provide care related to the psychosocial domain. The healthcare chaplains nevertheless indicated that their assignment to the A&E placed pressure on their availability for both regular and emergency care. According to the healthcare chaplains, a call to the A&E takes an average of 4–5 h, thus making them unavailable for other emergencies during a large part of their shifts. In addition, because professionals from all hospital departments are present in the A&E, the healthcare chaplains working in that department receive more referrals from these other departments and, in some cases, they make follow-up contact with patients and their loved ones after they have left the A&E (see "Aftercare"). This situation places a strain on the—often small—teams.

Ability to avoid misconceptions

When healthcare chaplains arrive in the A&E, they often do not introduce themselves as such, due to the alarm that it may raise among the accompanying persons: "When

the healthcare chaplain comes, people immediately think, "This must be really bad." Or they think that we want to convert them to the Lord Jesus" (Healthcare Chaplain 2). Although such reactions to healthcare chaplains are common—given the prevalent traditional ideas about church ministry—they seem to be evoked more strongly within the intense and critical context of the A&E. For this reason, healthcare chaplains often introduce themselves as "family support" or as having come to support or listen to the accompanying persons. In the general experience of the healthcare chaplains we interviewed, accompanying persons respond positively to them, and other care professionals are becoming better acquainted with and appreciative of this profession.

Effects according to nurses

The nurses reported that the availability of healthcare chaplains provides them with a greater sense of peace and space for their tasks toward the patient. In addition, the support provided by the chaplains reduces the intensity of emotional outbursts in the A&E, which might be disturbing to others who are present.

The nurses indicated that they do not consider themselves fully competent to provide the type of support that healthcare chaplains provide accompanying persons, because they are more task-oriented. The nurses described the healthcare chaplains as being competent in listening, providing peace, and dealing with emotions.

Particular skills of healthcare chaplains

The healthcare chaplains participating in this study were also convinced that they have the necessary competencies for the task, although they do not think that these competencies are exclusive to their discipline. All of our respondents suggested that social workers could also fulfill these tasks, if they would be able to let go of their usual solution-oriented approach. They would also need to be sensitive to the existential dimension of the situation. The chaplains did not consider volunteers suitable for the task, given the major emotional impact and the expertise required.

Responding to the emotions of accompanying persons

The healthcare chaplains described their intentions as "ensuring that a traumatic event does not become a traumatic experience" (Healthcare Chaplain 7). Situations that were mentioned by all respondents as requiring care were those involving multiple victims, suicide, or when the people accompanying the patient are young, single, or both. At the top of the list were situations involving young victims. The respondents noted that the emotional responses of accompanying persons differ widely, depending on personality, previous experiences with loss and grief, and regional or cultural background. The healthcare chaplains reported that feelings of guilt are common among accompanying persons and the chaplains tend to respond to this with a combination of comfort and encouragement:

> "Did I do the CPR right?" Or they had called their daughter in the next town, instead of the emergency services. We made an agreement with other caregivers that we would always acknowledge their efforts. We don't say that they've done anything wrong; that is just not done. We comfort them: "You did the best you could. And then help arrived

quickly. It's great that you called, that you thought of that!" We place it in perspective. (Healthcare Chaplain 2)

According to all of the respondents, presence during resuscitation decreases the sense of blame that accompanying persons sometimes shift to care professionals. Some accompanying persons blame dying patients for abandoning them. In such cases, health-care chaplains suggest that this should be expressed to the patient (carefully) or to the healthcare chaplain.

Addressing the needs of accompanying persons

The healthcare chaplains participating in this study confirmed the findings in the litera-ture concerning the wide variety of needs on the part of accompanying persons, both between different situations in the A&E and between different people in the same situ-ation. Moreover, the needs of a given individual change constantly and rapidly. This requires healthcare chaplains to be capable of shifting easily between many different roles and tasks. Although there was some discussion concerning which tasks belong to the healthcare chaplain, all of the respondents agreed that all of the tasks should be ful-filled and that they should thus provide integrated care. We discuss this in greater detail below.

Facilitating understanding

According to the healthcare chaplains, the first need that accompanying persons have, is to arrive at an understanding of the present situation. The constant reordering of the available factual information is important in this process. "People will tell the same story five times. It is important to allow that story each time and to look at it from all sides" (Healthcare Chaplain 3). For this reason, these respondents identified being pre-sent and listening as the most important task in the A&E.

Supporting significance

According to the respondents, discussions of the fundamental nature of the situation (for example, "Why her?") are rare in the A&E, because the situation is still too critical or incomprehensible. In their experience, these types of questions should be understood as an utterance of despair or bewilderment that needs to be vented, and not as ques-tions that require answers. Nevertheless, when the acute story (understanding) has slowly taken shape, the accompanying persons begin to speak about the life stories of patients as well, highlighting characteristic traits, significant events, and/or meaningful joint experiences. Accompanying persons apparently differ greatly in how soon they begin to talk about the patient's life. According to the respondents, this tends to happen more quickly with older patients. With younger patients, devastation slows down the process. The healthcare chaplains indicated that they encourage accompanying persons to share such stories with each other, to lighten the current circumstances, and to begin the coping process by making sense of the situation:

> That they name the beautiful moments that they had together, and the crazy times—that gives strength. What we try to do is to reduce the threat and strengthen the resources. To

stress that the connectedness that they had felt with each other is something that they wouldn't want to have missed. (Healthcare Chaplain 5)

The healthcare chaplains suggested that their presence may highlight this dimension of meaning, as people tend to associate it with them or because they are more sensitive to this process. In the A&E, however, the dimension of significance can be overruled by more instant or practical concerns, which can arise suddenly.

Performing rituals

According to the healthcare chaplains, rituals can have an exceptional influence on the situation, and they identified this as their unique contribution. They spoke of intimate and healing ritual moments, about which accompanying persons had expressed gratitude in letters, at commemorative meetings at the hospital or during unplanned encounters. The healthcare chaplains did experience reservations with regard to offering ritual guidance in the A&E, given the negative religious connotations that it could have for accompanying persons and given the profane atmosphere in the A&E. The healthcare chaplains reported that they make their own assessments concerning the need for rituals, and then subtly suggest the possibility to the accompanying persons. They subsequently work together to search for a suitable ritual that is suited to the life views of the accompanying persons. In some cases, these rituals consist of very small symbolic gestures, like holding the hand of the patient or drawing attention to possibly significant details (such as a peaceful facial expression).

Guiding proximity at resuscitation

According to all of the respondents, most accompanying persons prefer to be present during resuscitation and, when in doubt, the chaplains encourage them to do so. Although presence during resuscitation is not standard practice, it is advocated in the Netherlands, because it seems to reassure the accompanying persons that everything possible has been done to save the patient. The nurses noted that they consider it important for the healthcare chaplain to be present alongside the accompanying persons during resuscitation, in order to provide support if the situation becomes too overwhelming and to ensure that someone will be present to keep the accompanying persons at a distance, if necessary.

Encouraging proximity after death

According to the respondents, almost all accompanying persons wish to see the patient after death. The nurses reported that they value this moment and take care to ensure that the patient is groomed before the accompanying persons are admitted in the room. The healthcare chaplains indicated that they often act as literal support to the accompanying persons when they go to see the deceased and that, once they have crossed the threshold, they often encourage closeness by suggesting a final kiss or touch to provide closure. Due to the intimacy of the moment, however, the healthcare chaplains also retreat quickly, in order to leave the accompanying person alone with the patient and with their grief.

Transferring information

All of the respondents indicated that accompanying persons have a great need for information, but that the sense of shock often makes it difficult to process that information. Healthcare chaplains therefore serve to relay information between the accompanying person(s) and the A&E. All of the respondents regarded this as a core task of healthcare chaplains in the A&E.

> I think I always keep an overview. That creates peace. (…) I tell them "Well, this is going on and this is happening, and in a moment, we will go there." That's why it is important to have that information. (Healthcare Chaplain 6)

The healthcare chaplains drew a distinction between practical information and medical information.

Providing practical information

Practical information consists of knowledge about how things are organized and which facilities are available. One telling example of the importance of such information was provided by Healthcare Chaplain 4:

> [the doctor said,] "I will be right back." I said [to the accompanying persons], "right back" means in two hours. Because they [the doctors] don't realize it, but to us, this is two times 60 times 60 seconds. And every second here is long, but they are working hard, and this is normal. Otherwise one might become very afraid.

The respondents noted that it is important for healthcare chaplains to know the clinical pathways and locations within the hospital (for example, between the A&E and the ICU or mortuary). This enhances trust on the part of accompanying persons, while contributing to the working relationship with other care professionals: "this is the only department where they [the other caregivers] call me a 'colleague'" (Healthcare Chaplain 1).

Having medical information

The healthcare chaplains considered medical knowledge important, because it allows them to provide proper support to accompanying persons, as well as to clarify any misunderstandings and to guide them to the right location. To avoid the blurring of responsibilities, however, all healthcare chaplains explicitly stated that it was the task of the physician to communicate this information to the accompanying persons. In some cases, the healthcare chaplain might advise the physician concerning the timing with which specific information should be presented.

Having detached concern

The healthcare chaplains described their attitudes in relation to the accompanying persons as "detached concern." With this attitude, they try to respect the emotional impact of the event, which requires sympathy, while also trying to respect the intimate and personal nature of the situation, which requires distance. According to the healthcare chaplains, the balance between distance and sympathy depends on the responses of the accompanying persons.

All of the respondents indicated that healthcare chaplains also have a more distinct position within the department, because they are not part of the primary care process and do not wear uniforms:

> When she [the healthcare chaplain] walks in, people are not immediately disturbed. She is of great value, but more discrete, not like when someone arrives in a white uniform, like me. When I enter the family room, people instantly start to wonder, "Oh, what is she going to say?" When I enter, all conversations fall silent. (Nurse 4)

At first, the specific position of healthcare chaplains makes it more difficult for them to become integrated into the department. On the other hand, this has the important advantage of being in a position of trust and confidence for the accompanying persons. More specifically, interactions with the healthcare chaplain do not have consequences for the care of their loved ones, and they provide an opportunity to vent any frustrations about the medical personnel.

Encouraging self-care on the part of accompanying persons

All of the respondents suggested that accompanying persons have little self-awareness during the situation, and that this prevents them from making good decisions about their own needs. This argument is also used to legitimize not asking for permission to call the healthcare chaplain, but merely informing the accompanying person about the availability of this service (after which they can always refuse, which rarely happens, according to the respondents). All of the healthcare chaplains also identified practical care as an important part of their duties: providing food and drinks, handkerchiefs, aspirin or other medications, or telephones (and chargers); arranging transportation and phone calls; and offering to take them to a family room or another place to rest.

The healthcare chaplains expressed ambivalence about these tasks, as they are not part of their profession, and they seem quite simple. The nurses, however, were very positive about the fact that healthcare chaplains took on these duties. The healthcare chaplains also suggested that providing for these practical comforts can serve as a good opportunity to connect with an accompanying person and that it has important symbolic value representing comfort, support, care, and security.

Monitoring the social network

The presence of other accompanying persons often diminishes the importance of the healthcare chaplain's role in providing support. Once a substantial number of people have arrived, who provide adequate emotional support to each other, the healthcare chaplain can retreat. On the other hand, it is not uncommon for tension arising from the situation to trigger existing conflicts within family systems. In such cases, the healthcare chaplain can serve as a mediator and protector.

Being present

The healthcare chaplains considered "being supportively present" as the foundation of the support that they provide to accompanying persons. The situations of existential and emotional turmoil cannot be resolved. The healthcare chaplains noted that supporting accompanying persons in their powerlessness, strong emotions, silences, or

withdrawal is suited to their specific expertise and professional attitude. The nurses also expressed appreciation for this "person-oriented approach." To the healthcare chaplains, being present means having the space and sensitivity to provide for the specific and changing needs of accompanying person.

The healthcare chaplains reported that they sometimes have difficulty ending the support. The emotional stability of the person and the presence of a social network (as noted above) are important signals that they can leave. In addition, healthcare chaplains retreat when accompanying persons give hints that they can manage on their own or when the patient is transferred to a different department or hospital. Upon departure, healthcare chaplains give their business cards to the accompanying persons, should they desire further contact (see also "Aftercare"). In addition, they usually debrief other care professionals.

Providing leadership

In addition to the more non-directive approaches discussed above, the healthcare chaplains also indicated that providing guidance is an important part of their tasks:

> We really have to look at this: "Is the family complete?" "Should people be called?" "Do you want to be with your father?" "Did you park in the right place? So where is your car?" "You know what, I will approach the doctor, because I can see you have many questions." Yes, in these matters, we are more directive. (Healthcare Chaplain 1)

This leadership role does not come naturally to the healthcare chaplains, as they usually play a more contemplative role in the support that they provide. As suggested by some of the healthcare chaplains whom we interviewed, however, the work is essentially the same, but it takes place in a shorter time span.

The amount of guidance provided depends strongly on how the accompanying person responds. While some begin arranging things adequately themselves, others need to be tempered because they might forget to take time to savor the final moments of their loved one's life. Conflict situations between accompanying persons or with staff members, dangerous situations (such as, emotionally unstable persons who want to drive home by themselves), and situations in which feelings of severe guilt prevent a person from savoring the final moments were also mentioned as demanding more explicit guidance.

Improvement of care

The respondents made several suggestions through which care for accompanying persons could be monitored and improved.

Aftercare

Both the nurses and the healthcare chaplains acknowledged that they do not structurally provide aftercare after a patient has left the A&E. Only sporadically will healthcare chaplains either call the accompanying person or visit them at home. The annual (or semi-annual) commemoration days that hospitals organize often provide a moment at which to meet the accompanying persons again and share their experiences. Several of

the nurses expressed that they regard the possibility of providing aftercare as an important asset of healthcare chaplains.

Evaluation

Little to no evaluation of the care is conducted with the accompanying persons. Such evaluation occurs only spontaneously, as when they send "thank-you notes" or meet the healthcare chaplains at the commemoration days organized by the hospital. More systematic evaluation is conducted with other care professionals in the form of annual or semi-annual meetings in the A&E, the evaluation of pilot programs, informal contact, or in particularly impactful situations (such as, victimization of children). In the latter case, healthcare chaplains are sometimes the initiators of the evaluation. Among the healthcare chaplains in the team, evaluation is incidental and informal. Several of the healthcare chaplains participating in this study indicated that they would like to have more structural evaluation.

Engagement in self-care by healthcare chaplains

Because of the acute, long, impactful, and sensitive character of the situation, healthcare chaplains experience their work in the A&E as highly intense and demanding. In the words of Healthcare Chaplain 4: "In the A&E, there is no routine." Situations that involve young people or that touch upon the personal histories of the healthcare chaplains are considered particularly impactful.

Despite the heavy demands, the professional challenge of such activity and the noticeable appreciation of other care professionals and accompanying persons combine to make the work of healthcare chaplains highly rewarding.

During a call

Some healthcare chaplains suggested that the intensity of such crisis situations sometimes cause feelings of reluctance before entering them. The chaplains noted that taking moments of rest before and during calls is very important to remaining concentrated and available. Maintaining a certain degree of mental and physical distance was mentioned as a vital way to prevent "heroism" or "losing oneself." Eating, drinking coffee, going to the restroom, taking a walk, retreating to a quiet place, self-reflection, chatting with nurses, or writing reports are ways to maintain the necessary distance and quality of support.

After a call

The chaplains mentioned venting to colleagues or their own family members, writing, and sculpting as ways in which they let off steam after working in the A&E. They nevertheless noted that they have little time to recuperate, as their regular shifts are difficult to postpone or cancel, due to the small size of the team. This threatens the health of the chaplains, especially in light of the fact that many are in middle age.

Discussion

This study provides rich information on the complexities of the care provided to accompanying persons by healthcare chaplains in the A&E departments of Dutch hospitals. Our empirical findings support and expand upon previous theoretical discussions about the competencies needed to support accompanying persons in critical-care settings. Previously identified competencies include psychosocial and communicative skills, knowledge of processes of mourning, flexibility, sensitivity, personal and professional reflexivity, and fast and continued availability (Davies, 1997; Dimond, 1995; Redley et al., 2003; Tye, 1996). Our findings support the need for these competencies. In addition, the respondents mentioned sensitivity to existential concerns, the practice of presence, a person-centered approach, medical knowledge, and letting go of a solution-oriented approach as important competencies for healthcare chaplains providing care to accompanying persons at the A&E.

The chaplains participating in this study also expressed that working in the A&E places a strain on them, because they had not been trained to work in such a fast-paced and high-intensity environment. They must constantly adjust the level of presence or guidance to the fluctuating needs of the accompanying persons, and this requires great sensitivity to the situation. These chaplains must also be sensitive to their own needs, and they must be able to perform the appropriate self-care that will allow them to cope with the long hours and to serve as a beacon within the storm of intense emotions experienced by the accompanying persons. Another challenge associated with assignment to the A&E is that it increases the case-loads of the—often small—teams of healthcare chaplains both directly and indirectly through increased referrals.

Despite the associated challenges, the availability of healthcare chaplains in the A&E seems to be highly valued by healthcare chaplains themselves, as well as by other care professionals in the A&E and by accompanying persons. We found that, in most hospitals, healthcare chaplains are on call for 24-h shifts, and they are not bound to any specific length for their consultations. This means that they can be available immediately and for as long as needed. Given that related psychosocial care professions are not required to be on call for 24 h at a time, and given the high work-pressure experienced by nurses in the A&E, this is an important asset of healthcare chaplains. The high level of availability is considered essential to good care in the A&E.

Our results provide evidence to support many of the needs mentioned in literature on accompanying persons in critical-care settings (Dückers & Rooze, 2011; Dykstra, 1990; Hallgrimsdottir, 2000; Leske, 1986; Redley et al., 2003; Redley & Beanland, 2004). In line with the high rate of secularization in the Netherlands, the need for religious practices was not mentioned often by our respondents, although they did discuss the importance of ritual gestures. Healthcare chaplains seem to be particularly skilled in helping accompanying persons to find understanding and significance in the situation, in performing self-care, and in enduring emotional responses to the situation. Healthcare chaplains help people to arrive at understanding by clarifying medical information and providing information about the care process, as well as by allowing accompanying person to find and share their stories. Although finding significance is not the primary concern for accompanying persons in the A&E, it does emerge in unpredictable and fragmented ways, to which healthcare chaplains can

respond with active listening or ritual gestures. The "outsider" position of healthcare chaplains makes them uniquely equipped to mediate between the needs of accompanying persons and those of care professionals, thereby serving as a beacon in the storm.

Further reflections

During the interviews, questions were raised concerning whether healthcare chaplains should be responsible for the more practical care tasks in the A&E (such as, pouring coffee). As also suggested by the respondents, however, such tasks contribute to the quality of the relationship with the accompanying persons, while offering a good starting point for conversation and helping the accompanying persons to find both emotional and physical comfort. These tasks thus seem to be an essential part of their duties.

The healthcare chaplains participating in this study were uncertain about how to demonstrate their own professionalism when introducing themselves to accompanying person, as well as with regard to using their ritual competence. Reflection on this issue between teams of healthcare chaplains and within A&E departments appears to be important.

Related to the uncertainties expressed above, further research is needed on the existential dimension within the experiences of accompanying persons in the A&E (Redley et al., 2003). In this study, we found that the sharing of meaningful fragments of the patient's life story was a way to help people find significance and maintaining their relationships with the patient. This narrative aspect thus seems to be the clearest manifestation of the existential dimension within the context of care for accompanying persons in the A&E. This may not be the only manifestation, however, and attention should also be paid to other, more subtle ways in which existential needs might emerge.

Another question arising within our interviews concerned whether healthcare chaplains have sufficient leadership skills, pragmatism, and medical knowledge to fulfill the more directive aspects of their duties. Although the healthcare chaplains indicated that they had learned many of these competencies on the job, we recommend additional support through, for example, post-academic training.

Finally, more systematic efforts in the areas of aftercare, evaluation, and self-care by the healthcare chaplains could help both the healthcare chaplains and the A&E departments as a whole to improve their care and relieve some of the burden on healthcare chaplains.

Limitations

Social desirability bias may have played a role in this study, given that the healthcare chaplains were asked to reflect on their own work. In addition, no accompanying persons or physicians were included in the study. Inclusion of these perspectives might have led to a deeper understanding of the impact of and requirements for the provision of care for accompanying persons in the A&E. The responses of the healthcare chaplains were nevertheless supported by the information obtained through the interviews

with nurses, the observations in the A&E, and the available reports from pilot projects in the A&E.

Five of the ten healthcare chaplains and four of the five nurses who were interviewed were from the same hospital. In addition, our analyses made no differentiation between different types of hospitals or according to characteristics of healthcare chaplains or the care situation, and only a few nurses were interviewed. These methodological choices have implications for the generalizability of the findings. Further insight into the role of moderating factors in the organization and the quality of care could assist healthcare chaplains in making care decisions and developing their competencies.

In conclusion, healthcare chaplains seem to be a valuable resource in the A&E department, although better support is needed in order to ensure the sustained availability of these care professionals as a "beacon in the storm" for people in crisis. The research presented here can be used to develop training and coaching to realize this aim.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Note

1. The hospitality rating was an initiative of various Dutch hospitality and healthcare organizations, which ran from 2016 to 2018. Ratings were based on evaluations by the client council, clients/patients, employees, volunteers, family members and managers of the participating healthcare organizations, as well as on the results of an external audit.

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Appendix A. Interview form

Respondent data

Employer:
Name:
Position:
Age:
Years of experience working in the A&E department:

1. Organization
Is there a structural presence of healthcare chaplains in the A&E? Since when?
How many calls from the A&E does healthcare chaplaincy receive per year?

For what types of medical (or other) circumstances are the healthcare chaplaincy called? (Criteria)

Is there a protocol for the provision of support by healthcare chaplains to accompanying persons in the A&E?

Should support be provided to accompanying persons in the A&E department as a general rule? Why (or why not)?

Should this type of support be provided by healthcare chaplains? Why (or why not)?

How do healthcare chaplains and A&E staff members describe their experiences concerning such support?

How is the support by healthcare chaplains to accompanying persons in the A&E funded?

2. Being called in

How long does it usually take for a healthcare chaplain to arrive in the A&E after a call? (Absolute duration + in relation to the arrival of the accompanying person)

Are accompanying persons consulted in advance concerning the desirability of support? Why (or why not)? How does this work out in practice?

3. Role fulfillment

Positioning

How is the healthcare chaplain introduced to the accompanying person?

Who does this? Why this person? How is it done?

Please describe the situations encountered when arriving in the A&E (emotions, behavior)

Which role do you take as a spiritual caregiver? How do you decide on the role you will take?

Which factors are crucial to providing good support?

What is the greatest challenge in providing support to accompanying persons in the A&E?

Competencies

Which skills and expertise are needed?

Are spiritual caregivers sufficiently equipped for this task?

Which competencies are lacking or less developed?

Roles

How do you see your position in relation to the accompanying person? What is (or is not) your specific role?

To what extent is your role directive or passive?

To what extent is there conversation or silence?

What do you speak about?

4. Needs

Which types of needs do accompanying persons have?

Which needs are most important (at first, as well as later on)?

How do you (or do you not) cater to these needs? (Instrumental, emotional, informative, empowering)

5. Proximity and distance

How do proximity and distance take shape when providing support to accompanying persons in the A&E?

What is the role of other accompanying persons (in supporting the accompanying person who is closest to the patient)?

6. Relationship with A&E staff

How do the members of the A&E staff (doctors, nurses) value the provision of support to accompanying persons?

What role do doctors and nurses play in providing support to accompanying persons in the A&E?

7. Topics specific to chaplaincy

What makes healthcare chaplains suitable for providing support to accompanying persons in the A&E?

What role does meaning play during calls in the A&E department?

What role does religion play during calls in the A&E department?

What role do rituals play during calls in the A&E department?

What is the unique (specific) contribution of healthcare chaplains?

Could other professionals do this job sufficiently as well? Which professionals? What specific contribution would they make?

8. Aftercare and evaluation

What factors determine when the support is completed?

Is contact maintained with accompanying persons after the patient has been discharged from the A&E?

Why (or why not)? If so, by whom is the contact maintained?

Does the support provided to accompanying persons continue after the patient has been transferred to another department within the hospital, discharged or died? Why (or why not)? How often? How?

Is feedback received from accompanying persons? How?

Is feedback received from members of the A&E staff? How?

Does evaluation take place? How?

Could the support provided by healthcare chaplains in the A&E be improved? How?

9. Self-care

Do you prepare yourself for calls to the A&E? How?

How long does a call last? (Average, minimum, maximum duration)

What impact do calls to the A&E have on you personally?

What do you need in order to continue doing your work in the A&E?

Does the act of providing support in the A&E have an impact on you personally? How do you cope with that?

Is there space for and attention to self-care during a call?

Is there space for and attention to self-care after a call?

Finally

Are there other topics or experiences that are worth mentioning?

How have you experienced this interview?

Thank you for your cooperation!