Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Emergency department approach to spirituality care in the era of COVID-19

In the era of COVID-19, physical distancing measures have been widely implemented to limit viral transmission. Hospitals across the world have restricted visitation except under extenuating circumstances. Under these conditions, many critically ill patients are treated without the comfort of loved ones at the bedside; this can have negative outcomes for both patients and their families.

An increasing focus on the intangible elements of patient care, including familial support and spiritual care, has led to the implementation of holistic patient-centered initiatives in many hospitals. A vast range of patient and family needs is seen in the emergency department (ED), where it is necessary for chaplains and spiritual care professionals to be incorporated into the patient care team [1-5]. Therefore, addressing the spiritual and psychological needs of patients and families has become critically important during this public health emergency. We present a simple two-pronged method that can be implemented in hospitals during extraordinary times, such as pandemics, to improve holistic care of patients and their families: Prong one involves immediate post-resuscitation care of the patient followed by care of the patient's family members who may be unable to be physically present and prong two involves utilizing hospital staff to facilitate direct communication with family when visitor restrictions are implemented.

After the death of a patient, some institutions have implemented a 30 s post-resuscitation "pause" during which all members of the resuscitation team momentarily suspend all tasks and silence the monitors [6,7] Hospitals have implemented these pauses for three reasons. First, it allows members of the team to honor and recognize the life of the patient. Second, there is recognition of the emergency team's collective effort to restore this patient's life, and third, it provides emergency clinicians the opportunity to psychologically transition from a resuscitation event back to routine functions. Our approach (Fig. 1) begins with this post-resuscitation pause not only to provide the aforementioned benefits but to allow time to address spiritual and faith-based interventions on behalf of the patient and family (Table 1).

Rather than a simple moment of silence, this pause could be personalized by using the patient's name and acknowledging that a human being who was special to someone and productive in this world had just died in the presence of the resuscitation team. Furthermore, should the patient's spiritual or religious preference be known, a member of the team who has undergone prior training could include a 2–3 sentence contemplative testimony. This allows clinicians to provide spiritual care when physical limitations have been met (Table 2).

We also propose that a non-pastoral spiritual care team, trained by chaplains and the palliative care department, lead the intervention (Fig. 2). While these measures could be implemented quickly, training by these teams will equip hospital staff to feel comfortable addressing families and providing holistic end-of-life care on an emergent basis [8-12]. These staff can use multidisciplinary spiritual and faith-based interventions when chaplains are unavailable.

As the dynamic of medicine increasingly shifts to focus on a patient-centered model, the notion of family-centered care has gained traction as well. The American College of Critical Care Medicine outlines family-centered care as the ideal practice for end-of-life care [13]. In the intensive care unit (ICU), family presence at the bedside is becoming a widely adopted tenet of care, as it has been linked to noteworthy benefits. Namely, family visitation in the ICU has been associated with a shorter length of stay, improved outcomes, and a decrease in anxiety and post-traumatic stress disorder [14].

While patients and their families appreciate speaking to physicians, it is important to recognize and utilize the role of additional team members, particularly nurses and pastoral care providers [15-18]. Nurses often have some of the closest and most sustained contact with the patient and family, and families often find consolation in speaking with the patient's bedside nurse [19]. Moreover, surveys have found that pastoral care providers perceive nurses as spiritual care providers [18].

There is evidence to support the use of telemedicine to connect chaplain and patient as well as chaplain and patient family members [20]. While the role of "tele-chaplains" has yet to be fully explored, many chaplains have incorporated electronic communication in other aspects of ministry and, thus, may feel comfortable with this format [20]. In the context of the patient's critical health status, tele-chaplains could pray remotely with patients and their families, an intervention that has proven to improve the quality of life for patients near death [21].

In the COVID-19 era, many hospitals implemented visitor restrictions and limits to the number of care providers allowed in patients' rooms [22,23]. In the face of such challenges, these proposed additional spiritual care measures are increasingly important, not only to ensure respect of patients but also for the well-being of their families. We hope that these measures can be extended across various departments of the hospital and persist beyond times of crisis to be used during everyday practice.

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Diversity

Our authors are diverse in background, career stage, gender, and religion.

Declaration of Competing Interest

The authors do not have a financial interest or relationship to disclose regarding this research project.

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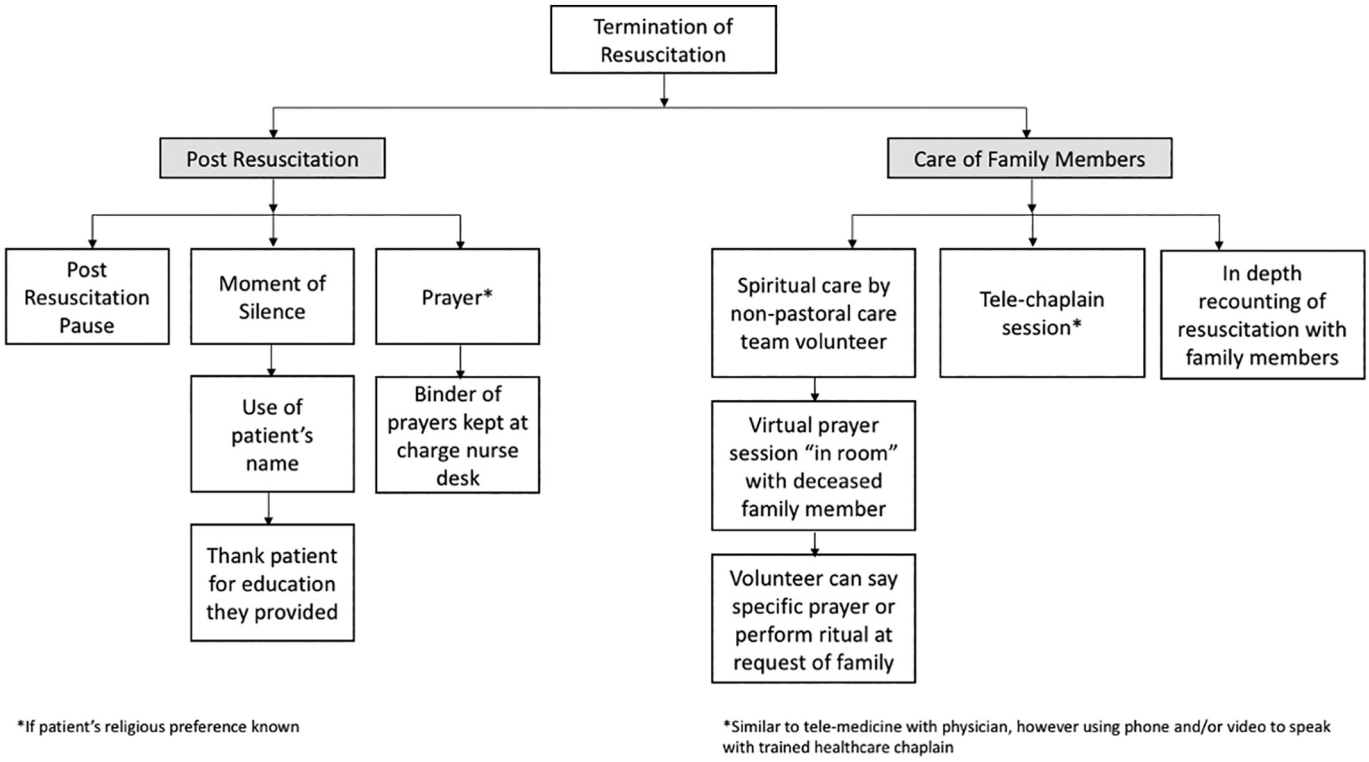

Fig. 1. Spiritual based interventions after termination of resuscitation during pandemic or other public health emergency.

Table 1
Option of post-resuscitation spiritual based interventions during times of pandemic

Proposal	Description	Benefits	Challenge(s)
Pause	- Pause all monitors and tasks	- Psychologically transition from resuscitation event back to routine functions - Recognize life of patient	Onus on someone in team to initiate
Moment of silence	- Use patient's name - thank patient for the education, take additional pause prior to returning to department	- Similar to pause, recognizes life of the patient - Provide gentle transition to providers	More time intensive
Short prayer	- 2-3 sentence prayer if patient's religious preference known - Led by code leader or any member of program at respective institution - Binder of prayers kept at charge nurse desk	Allow healthcare providers to offer one additional step in care of patient once physical care limitations have been reached	Patient's religious preference often not known May make some non-spiritual staff uncomfortable
Prayer session with staff member	- Member of SBI team gets called to hold prayer session with patient's family when chaplain not available	- More in person grieving/prayer with member of your own faith	- Having enough staff participating in the program willing to take time from their day to volunteer
Tele-chaplain	- Similar to tele-medicine visit, patient family has session with member of the chaplaincy	- Allows family to speak with chaplain virtually, although not as good as in person, still beneficial	- Price - Availability of chaplains willing to participate in virtual program

Table 2
Post-Resuscitation Pause, Script

Team Leader
Thank you everyone for your care of this patient. Before we go back to our busy job, let us take a moment to stop, thank, and honor this person's life.
Before this moment, they were a person with a life, a story, and memories. Perhaps they were someone's partner, child, or parent. To those people, who cannot be physically present with us today, they just lost a world.
We should also recognize what we learned from them and thank them for the education they provided us.
Although our medical interventions have been exhausted, let us honor who they were, their life, and their spirit, with 30 s of silence.

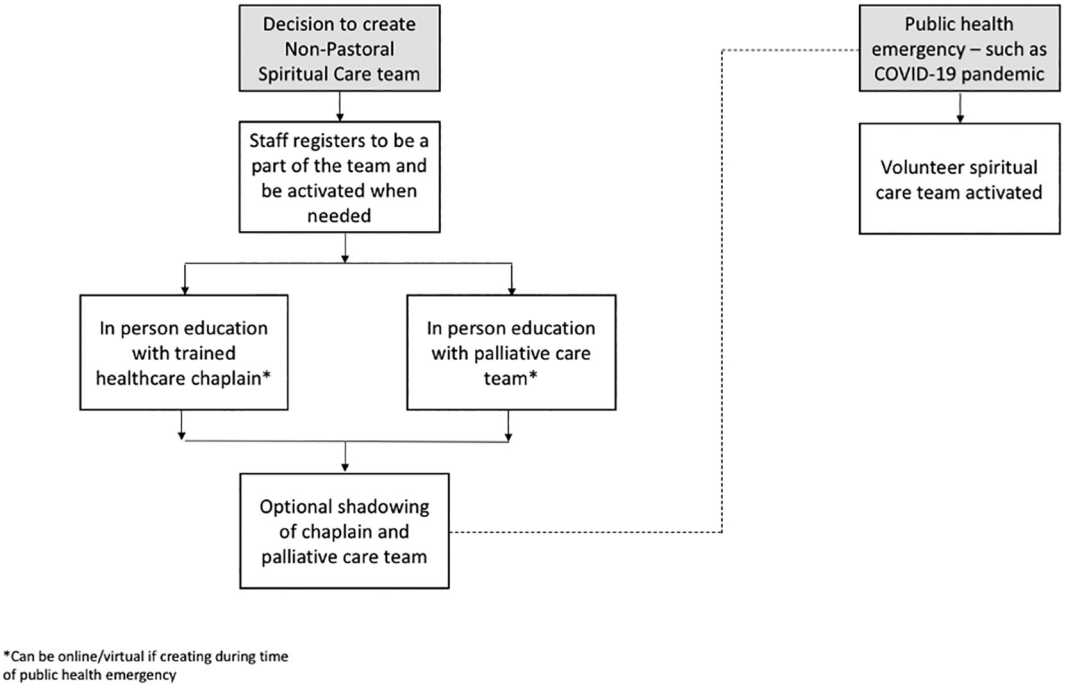

Fig. 2. Training algorithm once the decision to implement non-pastoral spiritual care is made.

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