Spiritual Support during COVID-19 in England: a scoping study of online sources

Abstract

Spiritual support is a key element of holistic care, and better healthcare professionals training and stronger strategic guidelines become urgent in light of health disasters and emergencies, such as the COVID-19 pandemic. To this end, the aim of this study was to explore spiritual support provision within mass and social media and the websites of spiritual leaders, institutions and NHS chaplaincy units during COVID-19 in England, between March and May 2020. A scoping review design informed by Levac and colleagues' five-staged framework was adopted, and adapted with a multi-strategy search to scope the different domains of online sources. Results revealed that spiritual support for dying patients, their families, health care staff, spiritual leaders and chaplains, had to be drastically reduced, both in quality and quantity, as well as being provided via different technological devices or domestic symbolic actions. No mention was found of a central strategy for the provision of spiritual support. This study points to the importance of developing centralized strategies to prepare healthcare systems and professionals in relation to spiritual support provision, both routinely and during health disasters and emergencies. Further research will have to explore innovative practices, in particular the role of digital technologies, in spiritual support provision.

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Introduction

The World Health Organization declared the outbreak of COVID-19 a pandemic on the 11th March 2020, and less than two weeks later, the UK Prime Minister announced the implementation of several restrictions advertised by the slogan "Stay home, Protect the NHS, Save Lives". The infection and death rates increased rapidly, and during the early weeks of the COVID-19, the UK government and the NHS were not fully aware on how to best approach its treatment and prevention and were unprepared for this health emergency (The Guardian, 2020). The UK is one of the top twenty countries affected by COVID-19 worldwide, scoring fifth for number of cases and deaths; this implies that the burden of COVID-19 has been very high, with - at time of writing – over 61,200 deaths and many more spending days, or weeks, of suffering and/or being ventilated artificially in intensive care before most of them dying (Johns Hopkins Coronavirus Resource Center, 2020). Both anecdotal accounts and evidence from available studies around spiritual care during COVID-19 emphasized the lack of spiritual support (Ferrell et al., 2020; Ribeiro et al., 2020; Roman et al., 2020), as well as the lack of preparedness within the healthcare systems, which were found not to be equipped to enable staff and spiritual service providers to respond to those in need.

Spirituality is an integral part of being human (Author, 1999), and spiritual care is a key element of holistic care pivoting around compassion and cultural competence (Author, 2018). Research around the benefits of spiritual support is advancing and new evidence corroborates the fact that patients with advanced illness, and those dying, find considerable comfort from prayer, or just the presence of someone who can hold their hand and be with them as they take their last breaths (Ho et al., 2018; Author & Author, 2005). A recent

literature review (Ho et al., 2018) identified several benefits associated with meeting the spiritual needs of patients in intensive care units, such as perceived improvement in care quality, enhanced patient satisfaction, and a better perception of care among family members. Similar results are reported in a recent systematic review of spiritual support in terminal illness (Chen et al., 2018), and indicate that spiritual care can improve care quality and patients' wellbeing, as also found in a study focusing on patients' perspective (Ebenau et al., 2020). Echoing these findings, a third review in palliative care in Europe showed that the effects of spiritual care are positive, particularly in terms of reducing patients' discomfort (Gijsberts et al., 2019).

Nurses have a historic role in supporting the spiritual well-being of patients (Royal College of Nursing, 2011), and, as a study with acute care nurses in New York City found (Gallison et al., 2013), addressing patients' spiritual needs is considered part of their role. However, the same study also reports that only nearly half of the sampled nurses declared to participate in spiritual practices due to several barriers, including lack of time, convictions around the privacy of spirituality, difficulties to provide it when beliefs were different from their own, and also difficulties to separate it from proselytism (Gallison et al., 2013). These findings resonate with those of another study where nurses working in End of Life (EoL) found to provide less spiritual care than they desired, reported inadequate training and that the idea that spiritual support was not lying within their professional role. These factors were also key predictors of reduced spiritual support (Balboni et al., 2014). Another study reviewing the literature around barriers to spiritual care for nurses in hospital settings, found that scarce clarity around the definition of spirituality, the dearth of training, time and guidelines for nurses' role were the main issues concerning the provision of holistic care that includes spiritual support (Rushton, 2014). Current outcomes of training in spiritual care appear promising (Dezorzi et al., 2019; Hu et al., 2019; Paal et al., 2015), and studies have

discussed the importance of incorporating spiritual care into basic educational activities and models, in palliative care and beyond (Best et al., 2020; Piscitello & Martin, 2020).

Meeting nurses training needs and developing strategic guidelines in the realm of spiritual care becomes urgent in light of disasters and emergencies being on the rise worldwide (Chapman & Arbon, 2008; International Federation of Red Cross & Red Crescent Societies, 2018). International institutes urge governments to strengthen strategies for disaster reduction with concrete management plans (ISDR, 2007; WHO, 2019), which include disaster preparedness training of all healthcare professionals (Achora & Kamanyire, 2016; Schultz et al., 2012). Nurses represent an indispensable workforce during disasters (Magnaye et al., 2011), and preparedness for adequate response is crucial (International Council of Nurses & World Health Organization, 2011). In mass casualty situations, the demand for spiritual support grows exponentially with the death toll, and nurses bear one of the greatest burdens of care, including that of patients' spiritual well-being (McBrien, 2010). Nonetheless, research and strategies around emergency and disaster preparedness in relation to spiritual support appear scarce. In England, the NHS programme of work known as Emergency Preparedness, Resilience and Response (EPRR) (NHS England, 2017) appears to be lacking plans to prepare nurses and their managers in relation to spiritual support, including during pandemic influenzas and other infectious diseases (Sellwood, 2017).

Aims of the study

The primary aim of this study was to explore and report how and what spiritual support was covered by mass and social media, the websites of spiritual leaders/institutions and those of the UK NHS during the early peak of COVID-19 in England. A secondary aim of this study was to comment on the existence of national strategies for dealing with major hazards and disasters and, in the case of their absence, to highlight their need (Author et al., 2020). There is no universal definition of spirituality, due to its subjective nature and focus

on the 'self' (Sinclair et al., 2006; Walton, 2012). Accordingly, spiritual care is associated with several interventions, including healing presence, patient- and meaning-centredness, and the establishment of a spiritually rich environment (Ghorbani et al., 2020). In the present scoping study, spirituality is defined by four universal dimensions and some individual meanings (see Box 1). Furthermore, the term spiritual support is preferred, since it is broader than spiritual care, which is commonly used and investigated in nursing care (Ramezani et al., 2014; Royal College of Nursing, 2011). In the WHO ICD – 10/11-AM Spiritual Intervention Codings (WHO-SPICs), spiritual support is described as "the provision of a ministry of presence and emotional support to individuals or groups", and is only one component of spiritual care, along with assessment, counselling, guidance and education, ritual, and allied health interventions (Carey & Cohen, 2015; Carey & Gleeson, 2017; WHO, 2017). In this paper, we use the term spiritual support differently, as an integral component of culturally competent and compassionate care (Author, 2018). In this sense, spiritual support entails a spiritual presence, comfort and other actions not only to patients, but to their loved ones as well as health workers. Spiritual support stems from an "understanding [of] the suffering of others and wanting to do something about it [and] takes into consideration the patients' and the carers' cultural backgrounds as well as the context in which care is given" (Author, 2018, p.2). This conception of spiritual support is intended to apply to all healthcare professionals, from nurses to medical clinicians, and is not restricted to the professional interventions of chaplains.

Methodology

This scoping study is informed by the framework originally proposed by (Arksey & O'Malley, 2005), and further developed by Levac and colleagues (Levac et al., 2010) and Peters and colleagues (Peters et al., 2020). According to this framework, the review has been organised into five stages (i.e., 1. identifying the research question; 2. identifying relevant

sources; 3. sources selection; 4. charting the data; 5. collating, summarising and reporting the findings) and adapted to scope evidence different from academic and grey literature, i.e., online sources such as websites, and social media postings in Facebook and Twitter.

Identifying the research questions

The following research questions guided the scoping study: a) To what extent has the provision of spiritual support for the COVID-19 hospitalised patients been covered by mass and social media and the websites of spiritual leaders/institutions and those of the NHS, in England, in the period between 20th March to 20th May?; b) How has the provision of spiritual support for the COVID-19 hospitalised patients been represented within by mass and social media and the websites of spiritual leaders/institutions and those of the NHS, in England in the period between 20th March to 20th May?; c) Has the COVID-19 pandemic affected how spiritual support is conceived, valued, and given within the NHS in England in the period between 20th March to 20th May?; d) What are the lessons we can draw from the findings of this study?

Identifying sources

This scoping review considered sources available online only, and searches were conducted on the World Wide Web (from now onwards 'Web'), on relevant organisations' websites, and on selected online mass and social media. The search strategy was articulated along four main domains and piloted for each of them. Pilot searches confirmed the general appropriateness and feasibility of the search strategy, and the only modification to the protocol that the research team agreed, was the abandonment of the search term "support" because it appeared to be yielding too many irrelevant sources (sources not related to spirituality but to other types of support such as the provision of support in the community, for example, the delivery of food to vulnerable older adults).

Search strategy 1. Search of the Web using the free text terms and sets of combinations always including "spiritual", "COVID19", "patients", and "England", in combination with other terms such as compassion, spiritual leaders, chaplains, and hospitals. Examples of search terms combinations are provided in Box 2.a. The pilot search with this strategy indicated that, after 100 Google results using a specific set of terms data, saturation was reached. After scanning 500 Google results, using five different terms' combinations, no relevant pages were being generated and this search was concluded.

Search strategy 2. The websites of relevant institutes and organisations concerned with healthcare and spirituality were searched. These organisations were either established a priori, based on the knowledge of the research team, and involved international organisations which include UK/England as member (i.e., Box 2.b); or they were identified via the previous Search strategy 1; or via snowball sampling.

Search strategy 3. Selected online TV news outlets (BBC News and ITV News) and online newspapers (The Sun, The Daily Mirror, The Guardian, and The Daily Telegraph) were searched using the Google search engine. The same key terms presented above, in Search Strategy 1, were used to explore these selected sources.

Search strategy 4. The following social media were searched: Facebook and Twitter. For the latter, a series of hashtags # associated with above search terms (Search strategy 1) were used (see Box 2.c). Specifically, Twitter and Facebook accounts of key spiritual leaders, such as the Church of England Archbishop, leaders of the Catholic Church and churches of other denominations and other religions were also identified and searched (see Box 2.c). Inside these potential sources, a search of all of the posts published within the study time range was conducted, and these were filtered for each hashtag and search term.

All searches were conducted between June to August 2020, using Safari and Google search engines. To assist with managing the collation, screening, and extraction of data,

searches were divided among the research team members in the following three domains: 1) search of the Web with Google and organisations websites; 2) on-line mass media; and 3) social media (Twitter and Facebook). All sources identified by searches for potential inclusion were downloaded in full-text onto Word files kept by each researcher. No special software was used for the management of the search results, and files were shared among the research team in a secured OneDrive cloud folder. Figure 1 summarises the selection of sources in accordance with PRISMA guidelines, and following the search strategies above delineated.

Sources Selection

Only sources dealing with spiritual support – as per working description used in this paper (see Box 1) – relating primarily to hospitalised COVID-19 patients, relatives and caregivers (including spiritual support providers) according to the following categories: a) semantic field (terminology and synonyms); b) as formalised in nursing and healthcare (spiritual care, palliative care and chaplaincy); c) ideas and conceptions (common, lay understanding); d) actions and initiatives (petitions, fund raising, awareness raising); e) impact of COVID-19 onto spiritual support provision.

The source of information/stories could be about the patient, the nursing staff, the spiritual leaders, the families of patients, a journalist interviewing the above, a friend of the patient or family. No age or demographic restrictions were applied, apart from the context which was limited to England, and the source language which was English. Only material published online between 20th March and 20th May 2020 were considered, because this period represented the peak of the pandemic in England, UK (first wave). However, in relation to sources in Search strategy 1 and 2, where the exact date of publication was not always available, the team decided to consider that sources from hospitals were falling within the study time range as well as some of the resources providing advice and resources, because

there were some references to phenomena and events linked to the first two months of the pandemic in England, e.g., Easter, or high numbers of dying patients, or self-isolation and lockdown. If a source was slightly post-dated, but clearly referring to occurrences which happened within the study time range, it was included. Academic literature of all kind, and sources not available online were excluded.

Charting the Data

Details and data from included sources were extracted using a standardised piloted data extraction form employed by each researcher in their own search domain. Information that was charted included two broad categories: 1) Evidence Source Details and Characteristics (bibliographic information with URL and date of access); 2) Details/Results extracted from source of evidence (context, target population, key findings that relate to the project's review questions - e.g., action/initiative described, link between COVID-19 and spiritual support, how spiritual support is described, other - on some occasion accompanied by direct quotes.

Methodological excellence and accuracy

According to Denzin and Lincoln (2017) qualitative researchers should be more concerned about methodological excellence and accuracy rather than validity; they should be concerned with transferability, rather than generalisability, and dependability, rather than reliability. The authors believe that this study met all these criteria in a number of ways. All procedures were carefully developed and discussed by the five members of the team, and were subsequently piloted and adjusted accordingly. This assured accuracy in the data collection, and dependability in the analysis and interpretation of the results. To increase accuracy and dependability, each researcher independently verified the work of at least one of their colleagues and the whole team had regular meetings to discuss all processes and result.

The authors believe that the findings provide detailed evidence for transferability as the results will resonate with many nurses and other health professionals.

Results

Given the heterogeneity of sources and data in this review, results are presented separately for each of the three search domains. Findings are presented as follow: employing a narrative synthesis rich in direct quotes – for the online mass media domain – and using a descriptive synthesis for the domain of organizations' websites and of social media. Table 1 synthetises overall results by search domain, offering both key figures of the types of spiritual support actions/initiatives and of sources included per thematic categories, and key sub-themes. A link to the project report section per each thematic category is provided [insert Table 1 here]

Online mass media domain

In the selected mass media, the provision of spiritual support for hospitalised COVID-19 patients received little mentions and no relevant stories were found in either of the TV news websites. The newspaper reporting represented spiritual support as an integral part of care for patients, staff, and relatives, and the efforts made by staff to provide such support under such extremely difficult circumstances were particularly valued (see Box 3.a). Particular attention was given to innovative approaches that were adopted for providing spiritual support for patients being treated in isolation – essentially virtual spiritual support – and to some exceptional cases of spiritual leaders secretly acting as volunteer chaplains who were playing an active role in providing spiritual support, despite the risk (see Box 3.b).

Domain of organizations' websites

The majority of sources consist of evidence of remote action, where spiritual support is offered over the phone, or via statements of support, or where strategies for support at

distance are suggested which do not necessarily entail the use of technology, or sets of online resources for self-spiritual support – essentially prayers and links to videos; nine sources consist in testimonies of front-line spiritual support providers working in hospitals, hence being evidence of bedside spiritual support (see Table 1). Other sources consist of documents such as guidelines, protocols, and information from NHS hospitals or religious organisations. If we exclude hospitals and Trusts' chaplaincies (n = 19), sources coming from religious organisations, including interfaith coalitions (n = 14), outnumbered those from non-denominational bodies (n = 10). It is important to notice that one source could belong to more than one type of evidence, for example guidelines and informative communication could be found together with the remote action type. Evidence is described below following the four main categories in which sources have been grouped according to the main target population in receipt of spiritual support.

The main modification in the provision of spiritual support to patients has been its 'virtualisation', thanks to the use of technological devices. Secondly, where in-person bedside spiritual support could be offered, this had been reduced both in numbers - as often only emergency cases could be catered for - and in quality, due to the heavy PPE that the spiritual support providers or staff always had to wear. Spiritual support provision for relatives was affected both in terms of being unable to exchange support with their sick loved ones, and to receive it from chaplains and spiritual leaders. Congregational rituals had to be suspended, and relatives were in quarantine, therefore celebrations and commemorations had to occur virtually from home, and in solitude, including funerals and requested masses by name. Other sources offered strategies to relatives in order to establish invisible connections, such as lighting a candle, practicing mediations, listening to music, etc. When chaplains could be visited, or when they could visit the loved ones in hospital and act as live bridges between relatives and patients, this was described as a great source of comfort.

Healthcare staff have also been affected by the reduction in spiritual support provision due to the pandemic. Accordingly, an increase in the request of chaplaincy service on behalf of staff was noticed, and in a few (n = 4) structures new services were set up, or old ones intensified, such as a staff support line run by chaplains working from home; group reflection sessions; informal staff 'well-being hubs' around the hospital; and occasionally one-to-one support. In those few hospitals (n = 11) where chaplains and spiritual leaders could be present in person, results indicate that this was of comfort to staff. Frontline staff have been the first providers of spiritual support themselves, and while a few guidance documents in relation to the provision of spiritual support during this emergency were found (n = 7), they appear very generic and, in many ways, almost identical to common chaplaincy guidelines which are focused on preparation rather than actual doing. Results suggest that spiritual support among spiritual support providers has been either peer-support or self-help/self-care, with instances in the sources describing leaders crying on each other's shoulder, or strengthening their coping skills with a morning prayer and affirmation.

Social media domain

Twitter

Data were aggregated in four main categories, and for each of these a short descriptive synthesis is provided. The first category has been named 'Tales from the Hospital'. While a large range of tweets connected with the hospital overall, there were also tweets regarding controversial issues, such as the provision of PPE (n=2), differences between NHS Trusts around their policies to spiritual support (n=3), or the inadequate hospital resources and facilities and the re-purposing of mosques to be used as hospitals. Several tweets referred to the public thinking about the great difficulty of those working in hospitals and praying for both patients and staff (n=5).

The second category focused on being a key worker. Scenes of moral suffering, where workers were required to prioritise healthy bodies over those of more elderly or disabled patients, were described. Elsewhere, "harrowing scenes" is the phrasing used in place of a more vivid description of hospital life. As a result, there is a recognition on social media that doctors and nurses working on the front line were themselves in need of spiritual support from hospital chaplains, in order to provide adequate care to patients. Furthermore, chaplains were also required to give training on EoL care to those clinical staff going to the frontline for the first time – such as student nurses. Broadly, a large body of tweets were praising – or advocating for praising – the work of the hospital chaplains.

The third category is where there is a discussion about the patient and their preferences, with a widespread recognition of the loneliness that patients in hospital were facing (n=3). Some chaplains commented about what it was like to support and reassure patients, who were dying without any friends or family beside them, with their eyes being the only part to be seen. In one Trust, patients' friends and relatives were encouraged to send in information and stories about the patients, which would be share with the doctors to ensure that each patient was "not just a number in bed". Similarly, another Trust promoted the "thinking of you" scheme, which encouraged friends and family members to send in messages for their loved ones, stating the ward, bed number and the surname of that patient. These details were printed and given to patients, and would not leave their side – due to risk of contamination – so that they could become a permanent reminder of the love and presence of their relatives.

Many tweets recognised the importance of the chaplain in enabling communication between the clinical team, patients and their family members. The importance of discussions around the EoL preferences and having the opportunity to say goodbye to a loved one was seen as essential for families to deal with grief. Some Trusts enabled patients to speak to their

families, by wrapping phones in plastic coverings and holding them next to the patients' ear. There was also acknowledgment of the importance of providing spiritual support to the family members to help them cope with bereavement, or anxiety around their loved one's EoL care. Many people discussed concerns over patients and staff members not being able to attend to their normal religious practices. Some religions offered "plenary indulgence" to patients, and absolution to staff members who were caring for people with the virus such. Chaplains in some areas sought to perform religious rituals for patients, such as by anointing them using cotton bud tips. Where allowed to approach patients, chaplains sought to offer respite to families by being there to witness the patient's death and being able to tell families what happened in their loved one's final moments. Finally, there were a range of tweets regarding funeral arrangements and conditions, such as the preparation of the body, whether or not the body could be buried or cremated, and who was allowed to attend.

Facebook

All posts were aggregated under one main theme, dissemination of information, as sources pivot around the provision of online worship services. Different organisations and individuals shared the schedules and/or events related to virtual worship, mass, days of prayers, spiritual talks, videos, and podcasts. They also shared documents and resources related to the disposal of the dead, ways of connecting with their church, temple, mosque, synagogue or others in order to received provided services.

Discussion

During the first peak of the COVID-19 pandemic, media reported that, due to safety regulations, many of the thousands of dying patients were deprived of the last act of compassion, in the absence of visitors, family members, or friends. Our results point to a general recognition that patients were often left alone and the restrictions in place created

tough conditions for them, their families and the organisations. In line with the recent WHO interim guidance (WHO, 2020), religious leaders, including chaplains, were unable to perform regular services and provide the same bedside spiritual support as pre-pandemic (Byrne & Nuzum, 2020; Cockell, 2020). The pandemic was considered as an extreme, unprecedented existential crisis, which caught health providers and the government unprepared in terms of a national strategy which had been well rehearsed and could be initiated and adequately resourced. The pandemic also created new societal systems and conditions of living, working and behaving, including how individuals care for themselves and others, when death is imminent (Bland, 2020; Blustein & Guarino, 2020).

A recent study exploring the treatment of lonely deaths among older people in Intensive Care Units (ICU), during COVID-19 and before, showed how dying alone lies out of social norms (Nelson-Becker & Victor, 2020). Dying alone is usually constructed as a form of 'bad death' (Seale, 2004), unless it reflects the individual choice (Turner & Caswell, 2020). Solitary deaths are seen as undesirable, and almost all cultures and societies have established collective rituals to ensure the smooth passage from the world of the living to that of the dead (Gennep, 2019). Our searches have detected that when the presence of someone could be offered, people expressed both gratitude and a great sense of comfort, corroborating the importance of holistic care, in ICUs and EoL particularly.

While low media coverage can be explained with editorial priorities focussing upon the startling rise in the number of cases of COVID infections and deaths, the reduction of bedside provision speaks to the unpreparedness of the NHS to deal with the scale of the pandemic, including the provision of a key service, such as spiritual support, as others have lamented too, for example in the US (Wakam et al., 2020) and Iran (Heidari et al., 2020). This further suggests that while some chaplaincy staff did still provide bedside spiritual

support (Swift, 2020; Theos, 2021), much of it had to be offered by clinicians, nurses and other healthcare professionals working in ICUs.

Our review did not find any mention of an overarching, national or regional, strategy for the provision of spiritual support by the NHS in response to a health emergency. The only initiative around disaster chaplaincy training we found looks promising (Guy's and St Thomas' NHS Foundation Trust, 2020), but it is far from being a systematised and coordinated approach throughout the NHS. A national strategy would better prepare, equip, and guide specialised spiritual and pastoral care units in case of emergency and disaster, including highly contagious epidemics (Author et al., 2020). Yet, it would also prepare all professionals across the system (Bornet et al., 2019), to cater for the spiritual support needs of patients, relatives, and themselves, in a time of severe spiritual suffering, and ethical challenges, around difficult treatment choices (Wakam et al., 2020). In fact, despite the increasingly recognised and inclusive role of chaplains within NHS England (Macdonald, 2019; Swift et al., 2015), frontline nurses continue to be key providers of spiritual support in emergency situations. According to Carey and Cohen (Carey & Cohen, 2015), in 2002 the WHO issued the Pastoral Intervention Codings (PICs) to record and account for the religious, pastoral and/or spiritual interventions of chaplains and volunteers providing care to patients. However, the same authors recommend that these codings should be further developed and promoted by the WHO in order to be viewed as accurate records of religious, pastoral and spiritual interventions. Our research did not specifically searched for, or explored the use of the WHO-PICs, although it would have been interesting to discover whether and how the PICs were used during the extreme and hugely different conditions which persisted during the first peak of the COVID-19 pandemic. Additionally, our review found that there was very little discussion about patients' own perspective in order to guide the provision of spiritual support in the future. Nurses are not the only ones to be best placed to inform

strategies and training (Veenema et al., 2016). Users' involvement is crucial in healthcare policy making (Pitts, 2020; Immonen, 2020).

Another key finding revolves around the notion of virtual and remote spiritual support. Our searches have yielded several instances of 'words', statements, generic guidelines, on-line resources, in addition to symbolic initiatives (such as drawing rainbows and clapping hands to the NHS, which we did not included in this study), rather than 'actions' on behalf of spiritual support providers. While this is all positive and understandable given the necessary social distance, at the same time it raises questions around the effectiveness of this new form of spiritual support and the changes in "being there" on behalf of pastoral and spiritual care teams (Swift, 2020). Remote spiritual support ultimately implies two evident, interlinked implications – digitally-supported self-spiritual support and the lack of physical presence – from which several observations could be unrolled. First, more insights are needed around how patients in ICUs, who mostly needed EoL spiritual support, could accept virtual spiritual support via the use of digital technological devices. Secondly, in relation to relatives, it appears that two keywords could well encapsulate their spiritual experience: solitude and intention (Cockell, 2020). Congregational rituals had to be suspended, and relatives were in quarantine and self-isolating, hence celebrations and commemorations had to occur virtually and individually from home, including funerals and requested masses. For non-religious relatives, other actions revolved around the intention to establish closeness in distance, such as lighting a candle or incense, meditating, playing some music, displaying a photo of your loved one. All these practices call for a reflection around the effectiveness of rituals and the changed in religion/religiosity (Baker et al., 2020), which traditionally entail the presence of a collective (Durkheim, 2008), and of the quality of the spiritual support offered, which pivots around dimensions pertaining to an interpersonal encounter (i.e., presence, being there, deep listening, compassion, hope, encouragement, connection, love, and talking together about

higher meanings). There is no doubt that digital technologies have proven their usefulness during the COVID-19 outbreak (Ting et al., 2020). Although studies are yielding promising results and found that people experience some comfort in giving/receiving virtual spiritual support, better understanding is needed to explore and improve new accepted conceptions and practices around spiritual support provision that the current pandemic has started unlocking (Betz et al., 2019; Drummond & Carey, 2020; Ribeiro et al., 2020; Swift, 2020), including the virtualisation and modification of rituals associated with spiritual support, such as 'being there', and new ways of 'dying well' and providing holistic care in our fast evolving contemporary society.

Limitations

This study presents limitations characterising the scoping review approach, such as no formal evaluation of studies' quality or risk of bias assessment, sizable number of studies included, need for multiple strategies, hand search and purposive sampling, overview results (Sucharew & Macaluso, 2019). Additionally, the research utilised the internet as both a tool and object of research inquiry. Organisations with no presence on the Web could not be included. Furthermore, organisational websites may not have accurately represented or provided information around their spiritual support services, while instead having some provision in place. Finally, while our multi-strategy search aimed to be comprehensive, our findings are necessarily cross-sectional and subject to fast changing and updating, due to the fleeting nature of the Web (Devan et al., 2019).

Conclusion and implications

COVID-19 pandemic has highlighted the crucial importance of spiritual support within the framework of holistic care, as a therapeutic healing tool for the body-mind-soul of the sick and dying, which helps reduce suffering especially in ICUs and EoL care. At the

same time, this health emergency has unmasked the urgent need for centralised strategies to prepare healthcare systems and professionals in relation to spiritual support provision, both routinely, but mostly during health disasters and emergencies. Finally, further research will have to explore the innovative practices opened up by this coronavirus disease in terms of spiritual support provision. In particular, the role of digital technologies is promising, in avoiding a reduction in quantity and quality of spiritual support, while maintaining safety and ensuring spiritual support needs of all are better met.

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