Chaplain Documentation: Recording Spiritual Care in a Clinical World
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Today’s Outline: Where We are Going
• The Role of the Chaplain
• Barriers to Chaplain Documentation:
  • Why this subject is frustrating so many
  • Common documentation “Boo-Boo’s”
• A “Thesaurus' for Spiritual Care records
• General guidelines
• Regulatory Requirements

The Importance of the Chaplain’s Documentation
• Describes the personal situation
• Provides a “whole-person” context
• Supports the significance of the services of the chaplain
• Ethical and legal accountability

The Struggle
• How does a chaplain enter a visit without an agenda when there is a form to be completed at the end of that visit?
• How to suspend judgment when clinicians are expected to solve “problems”?
• How to report the spiritual in the clinical record?

The Role of the Hospice Chaplain ...
• Palliative Spiritual Care
  • Addressing spiritual discomfort
  • Supportive ministry
  • Personal relationship/interaction
  • Empowering of another for spiritual work
• IDT member
  • Not a “Lone Ranger”
  • Team concept for patient’s benefit

...The Role of the Hospice Chaplain
• The Clinical Care Setting
  • Medical sciences
  • Problem oriented
  • Outcomes expected
The Role of the Hospice Chaplain

The tension: Spiritual care is not a science; yet, the spiritual caregiver must function and communicate in a clinical environment. And, this must be done without adopting the language & practice of the scientist to the sacrifice of the interpersonal and the mystery of the very nature of the "spiritual."

The chaplain’s documentation should provide descriptive of the patient’s spiritual strengths and struggles as well as provided to assist the patient along the spiritual journey. The of that assistance may be objective or subjective; immediate or cumulative.

Barriers to Chaplain Documentation ...

- No training
- Forms
  - Typically do not reflect chaplain activity
  - Often are not designed by chaplains
- Case load
  - Impacts depth of relationship with patient
  - Impacts time for follow-up

- Confidentiality conflicts
- Religious agenda confused with spiritual care
- Substituting psycho-social language for spiritual language

Common Chaplain Documentation “Boo-Boo’s”

Lack of documentation due to “confidentiality” & “confessional.”

- Not every chaplain's conversation is such.
- Suggestion: Document sensitive conversations in broad terms
- Avoid incriminating details.
- Record sufficient detail to enable recall and to allow the IDT to know what spiritual issues are present.
- Verbally communicate details to IDT on a "need to know" basis.
Lack of documentation due to “confidentiality” & “confessional.”

- Example: Not: “Patient confession... [SOME STOP HERE] of previous marriage and children she has kept secret from her present family.”
- Say: “Patient reflected on past relationships and the lessons learned from those journeys. Issues of forgiveness and grace and love were explored. She is at peace.”

Not Documenting Follow-Up

- If it isn’t charted ... it didn’t happen!
- “Will call family.” “Will call Social worker.” “Will call patient’s Pastor.” Requires follow-up note reporting the call and content of the call.
- “Patient desires communion.” Requires documentation of timely delivery of communion.

Not Documenting Referral

- If Chaplain charts: “Patient in such pain s/he did not want to visit today” there MUST be a note of referral to RN (by name) to report pain.
- Remind IDT to note your referral received and their response

Documentation Wording with Erroneous Implications

- Words and Phrases to avoid:
  - Patient is “stable”, “good” or “better.”
  - Patient is “independent.”
  - When these statements are true, document WHY they are true and make comparisons to previous visits.

Documentation with Erroneous Implications

- Example 1: Documentation for a Pt with Alzheimer’s states “Pt went to check on his cows.”
- Problem: Pt with Alzheimer’s who meets hospice criteria should not be walking and talking.
- The true story was something very different:

Pt’s buddies picked Pt up (literally), carried him to pickup, loaded him into truck, and drove to pasture.
Buddies talked among themselves about Pt’s cows.
Buddies took Pt back home and carried him to bed.
This was an act of friendship/love for a Pt whose life had revolved around care for his farm and farm animals.
Documentation Wording with Erroneous Implications

Example 2: Documentation of Pt with CHF states “Pt goes to get his mail.”
True intervention initiated by chaplain: Pt’s neighbor takes him in wheelchair to sit at the end of his long driveway. Pt waits for mail. Kids coming home from school wheel Pt back to his house.
Chaplain involved the community in adding to the Pt’s quality of life.

Documentation Too Vague

“Provided spiritual support.”
This is similar to an RN writing: “Provided pain management.”
Refer to type and purpose of the support.
Example: "Pastoral dialogue: patient expressed fears of dying process. Explored faith experiences of past and projected imagery of God and trust associated with future concerns. Contacted RN to provide education on the dying process and provide assurances of palliative care.”

Documentation Too Vague

"Read scripture and prayed with patient.”
Refer to purpose of the prayer and rationale for selecting specific scripture.
Example: "Read Psalm 23 and reflected on 'Thou art with me' to assure patient of Providence. Prayed for awareness of God’s presence and projected hopeful visions of heaven.”

Documentation Not Individualized

When the Plans of Care look the same for most patients, it appears that the chaplain is not individualizing care and ministry is repetitive.
Same is true for Assessments and Visit Notes.
Non-verbal patients challenge creativity in ministry. Family contacts will provide information that assists individualization of ministry and, thus, individualization of documentation!

Documentation

Remember: Surveyors have no personal experience with your patient or your visit
Documenting the whole story demonstrates the extraordinary measures taken to improve Pt’s quality of life.
Reinforces Pt’s hospice appropriateness and decline.
Gives credit for hospice interventions.

Other Boo-Boo’s???

Audience participation:

No names, please 😊
General Guidelines for Chaplain Documentation

...What (some) Surveyors will be Looking for ...and... What the Profession Might Expect To Find

The chaplain’s documentation should humanize the medical record as well as provide observations supportive of the clinical care.

General Guidelines for Chaplain Documentation...

- What are the patient’s issues related to life, faith, illness, dying, and death?
- What needs or concerns were expressed or observed?
- Recording unique cultural or religious preferences associated with the end-of-life. Was this communicated to the IDT?

...General Guidelines for Chaplain Documentation...

- Record the story that tells:
  - Who is this patient? Family?
  - Significant relationships? Dynamics?
  - Coping styles?
  - Religious preferences? Its meaning?
  - Spiritual perspectives? Its meaning?
  - Beliefs, thoughts, feelings toward afterlife?
  - Views of the future?
  - What the patient/family wants in the days ahead?

...General Guidelines for Chaplain Documentation...

- Observation:
- Identify the (spiritual) issues of concern:
  - Describe the need
  - Illustrate using quotes from the patient or family
  - Explain the need or concern using spiritual language whenever possible
    - EXAMPLE: Existential aloneness

...General Guidelines for Chaplain Documentation...

- Intervention:
- Document the intentional ministry:
  - Describe the purpose of the interventions.
  - May be what the chaplain did or will do.
  - Example: "Pastoral dialogue provided for reflection on fears associated with the afterlife."
  - Example: "Patient experiences increased awareness of God’s presence during communion. Chaplain will provide communion with family present 2x/mo.”
...General Guidelines for Chaplain Documentation

- **Outcome:**
  - Document the observed or reported results of interventions:
    - “Patient reports communion as meaningful and increases inner peace.”
    - “Patient seems less anxious partly as consequence to experiencing forgiveness.”
    - Results may be at each visit or a summary reflection following several visits made over an extended period of time.

A Thesaurus for Spiritual Documentation

An incomplete list of ideas

Observation: Use Words of Discernment

- The patient:
  - Wrestles with Desires
  - Is engaged in Is journeying toward

- Be cautious about using definitive, fixed statements. Spiritual care is a process involving movement, struggle, and change.

Observation: State the Spiritual Issue

- Providence
- Faith
- Hope/Future-Story
- Community
- Reconciliation
- Meaning/Purpose
- Guilt/Regrets
- Anger
- Trust
- Existential aloneness
- Peace
- After-life
- Letting Go of the Finite World
- Legacy
- Others?

Intervention: State the Activity

- Chaplain provided/will provide:
  - Ministry of Presence
  - Prayed for ___
  - Read Scriptures for ______
- Reflective conversation
- Spiritual Reflection
- Faith Expressions
- Conducted Ritual
- Provided Blessing
- Legacy
- Others???
Intervention:
Express the Purpose

◆ To allow the patient to reflect on life-story.
◆ To sustain/affirm faith
◆ To create awareness of __________
◆ To increase sense of peace
◆ To transform hope
◆ To explore faith realities
◆ To create meaning
◆ For communion with nature/inner self
◆ For discovery of the Sacred in daily experiences
◆ To reconcile with __________ Others?

Outcome:
Identify the results of ministry

◆ Expressed assurance
◆ Seemed less anxious
◆ Expressed emotion
◆ Reports increased inner peace
◆ Feelings were validated
◆ Felt affirmed
◆ Released stress
◆ Initiated reconciliation
◆ Greater sense of Providence
◆ Embraced spiritual assurances
◆ Felt forgiven
◆ Affirmed faith
◆ Released false hope
◆ Engaged a positive struggle of faith and reality
◆ Requested further dialogue

Example 1

◆ Patient struggling to reconcile beliefs with present realities. Chaplain provided reflective conversation to allow expression of spiritual disappointments and confusion. In future visits will provide Pastoral dialogue to facilitate examination of beliefs and allow for transformation of faith and integration with present events.

Example 2

◆ No meaningful communication from patient. Family reports patient was very spiritual and prepared for death. Chaplain provided ministry of presence, human touch, and faith expressions (Bible reading, Psalm 23 and prayer for total peace & trust) in order sustain faith. Family is encouraged by these faith expressions.

Example 3

◆ Family expressed anger associated with patient being “so young.” Chaplain reflected on traditional world view and encouraged family to express emotions. Chaplain encouraged family to interact with patient on this matter and educated family on ways to conduct such a conversation. Family expressed appreciation for validation of feelings.

Example 4:

◆ Patient expressed peace and anticipates heaven as reunion and joy. Chaplain provided spiritual assurances, prayers of thanksgiving, and projected imagery of the afterlife to strengthen patient’s hope.
Please feel free to forward other ideas for the Spiritual Care Thesaurus to:
Byendor@AOL.com

Regulatory Requirements for Chaplain Documentation

- Providing care that is “reasonable and necessary”
  - We are an indispensable part of the Team
  - The Pt’s well-being may depend on our presence and ministry (interventions)

- Initial Spiritual Assessment
  - Completed by qualified & competent staff
  - Completed within 5 days of admission
  - What if the Pt declines Chaplain services?

- Pt refusing Chaplain services is usually a matter of how the team presents the chaplain
  - Including specific religious preference (Muslim, Jewish, Jehovah Witness, etc)
- Discuss language used by Admissions team
- Preferably, each discipline should make their own introductions
- Offer “One Visit Then Decide” or a “joint visit.” Establish casual relationship with Pt
- Present spiritual assessment as a Medicare regulation

- When Chaplain Services are refused:
  - Document the conversation with the patient/family. Explain “why.”
  - Document the impact & outcome of the decision
  - Revisit this decision with the patient/family
  - Provide services to other family members when the patient refuses Chaplain visits (and visa-versa)

- Updates to the Comprehensive Assessment
  - Burden for updates must not fall solely to the nurse
  - Update every 15 days
  - By phone call or visit
    - This is NOT the IDT meeting
  - Document each update contact

- Identifying Spiritual Strengths
  - Spiritual “issues” vs. spiritual strengths and opportunities
  - Identifying the Pt’s goals
  - How does the Pt’s spiritual-state affect the Pt? The family?
  - How does resolution of opportunities/issues effect the Pt? The family?
 Regulations...continued

- Developing an individualized Plan of Care
  - Chaplain is expected to have input for spiritual issues/opportunities/struggles
  - Coordination with the IDT
  - Writing the Plan
    - Spiritual issues = strengths and opportunities; struggles
    - Interventions = ministry techniques/tools
    - Goals = what does the Pt want

 Regulations...continued

- Create a chain of events...
- Pt assessment (spiritual not physical) leads to:
- Identification of goals, leads to:
- Identification of interventions, leads to:
- New assessment and documentation of progress toward goals, leads to:
- Revision in the Plan of Care with new interventions, new goals, open or close issues/opportunities as needed

 Regulations...continued

- Contacting local clergy
  - Identify person contacted and plan
  - May need continued follow up
  - Develop your own contacts for local clergy and administration of rituals/sacraments
  - Document attempts to contact, and follow up with family

 Appropriateness and Decline

- All disciplines are expected to document (as appropriate) the Pt’s appropriateness for hospice care and the Pt’s physical decline
- Providing spiritual care may not look like decline, may look like opportunity
- Assist Patients in completing the developmental tasks for end-of-life

 Appropriateness and Decline

- Developmental Tasks at end-of-life
  - Dr. Ira Byock
    - www.dyingwell.org
- The Five Things:
  - “Please forgive me.”
  - “I forgive you.”
  - "Thank you."
  - "I love you."
  - “Goodbye.”

 Appropriateness and Decline

- Use hospice friendly words to describe what you see.

- Document only what is true.
A Few More Guidelines for Chaplain Documentation...

- Spiritual Assessment within 5-days of Admission
- Clearly documented refusals
- What will you do?
  - Based on what the patient/family wants
  - What is the choice of the patient that leads to the actions of the chaplain?
- How is the IDT involved? informed?
- Frequencies? Based on Spiritual Acuity?

...A Few More Guidelines for Chaplain Documentation...

- Documentation of objective and subjective needs.
  - Faith community affiliation? Viable relationship? Contact desired?
  - Rituals desired?
  - Recording of legacy?
  - Reconciliation with family members?
  - Preparation for the afterlife?
- Documentation of plan and resolution.

...A Few More Guidelines for Chaplain Documentation...

- Aspects of patient care that may not be specifically spiritual but affects quality of life.
  - Social well-being
  - Emotional well-being
  - Anxiety/Stress/Depression
  - Coping styles and abilities
  - Grief

...A Few More Guidelines for Chaplain Documentation...

- Coordination of Care with the Nursing Home Staff:
  - Note who was contacted
  - Document concerns reported and observed
  - Avoid numerous "patient was asleep" notes
    - Describe attempts to awaken or reason why not awakened such as "patient's ongoing confusion"
    - Note contacts with family

Give yourself credit for the good work you do by documenting your spiritual care to the patient and family!