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See you next spring in Chicago for the NACC conference!

We are happy to announce the first information about the 2016 NACC National Conference. We will be meeting Friday, April 22, to Monday, April 25, 2016, at the Chicago Marriott near O'Hare International Airport.

The Conference Planning Task Force has selected a theme of "Making All Things New: Co-creation, Transformation, Resilience and Hope." More details will be available soon.

Watch NACC Now in the coming weeks for our official "call" for workshop proposals. Please consider this opportunity to share your gifts as a workshop presenter.

Efforts to improve spiritual care can help whole institution

By David Lichter
Executive Director

We are very appreciative of the many members who have contributed articles to this issue of Vision on measuring quality in spiritual care. This is a challenging yet very important area.

I know some departments set their own goals to improve the quality of their work, whether it is by targeting improvement in the Press Ganey scores, through an associate survey on their performance, or setting improvement targets in their coverage or response time to referrals. Still, how do we understand the very concept of quality as it relates to spiritual care?

The important question also arises, "How do we integrate with and contribute to our hospital's or system's quality improvement initiatives?" The National Committee for Quality Assurance's publication, [The Essential Guide to Health Care Quality](#), refers to the 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, and its definition of quality health care as "safe, effective, patient-centered, timely, efficient and equitable." That publication also referred to the Agency for Healthcare Research and Quality's concise and memorable definition of quality care: "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."

We also know that the World Health Organization (www.who.int/management/quality/assurance/QualityCare_B.Def.pdf), in its 2006 document, adopted these six areas: effective, efficient, accessible, acceptable/patient-centered, equitable, and safe. So quality answers the questions: Does the service work? Does it maximize resources? Is it timely, in a reasonable geographically and in appropriate setting? Does it taking into account patient's preference and cultural sensitivities? Does it not vary to whomever and wherever? And does it minimize risk and harm?

Our quality improvement initiatives in spiritual care certainly should fit into our own hospital or system initiatives. In fact, the Institute of Medicine would postulate [direct correlation](#) between the (quality) indicators for improved health services and an individual's and a population's desired health.

How do our initiatives to improve our spiritual care service integrate with and/or contribute to the initiatives within our system? Do our improved contributions to electronic medical records and our more concise, clear narrative in the charts inform the members of the interdisciplinary team? Does it lead to better communication with the patient and family and more informed treatment choices?

These and many other questions will arise as we explore ways to evidence quality in our work. I hope you can use the articles in this issue, as members share their journeys toward more effective, efficient, and patient-centered care. We deeply appreciate their willingness to share their work in progress.

How do we measure quality in charting?

By David Lichter
Executive Director

We know chaplaincy has had to address several key business issues, such as productivity (what is done by a chaplain?), effectiveness (is it working?), and impact (can it be measured?).

Recently, however, the Quality Subcommittee of the CHA Pastoral Care Advisory Committee has been working on evidencing quality in spiritual care. The Institute of Medicine in 2001 defined quality health care as “safe, effective, patient-centered, timely, efficient and equitable.” Spiritual care providers need to take the lead in creating a culture of quality care and measure the quality of services. But what does quality look like in spiritual care? What is an improving quality in spiritual care? Over the past year or so, the PCAC’s Quality Subcommittee has tried to provide some answers. Along with me, members include Marie Parker, RSM, Director of Mission and Spiritual Care at Trinity Health; Tim Serban, Chief Mission Integration Officer at Oregon Providence Health & Services; and Mark A. Skaja, Vice President of Mission Integration and Spiritual Care at Mercy Health.

Determining Measures for Quality

The fundamental question was “How can we articulate an overall approach to and measure quality in spiritual care?” At the suggestion of Mark Skaja, John Meyer, vice president of the hospital efficiency improvement program at Mercy Health, provided a framework. The threefold approach considers process measures, outcome measures, and performance aligned with standards.

A process measure focuses on a process that leads to a certain outcome. So the questions are: Did you do it (services complete)? Did you do it right? Process measures can be isolated to a particular activity. For example, newly admitted patients are to be seen within 24 hours of admission, one is to chart within 30 minutes after the patient encounter, or the spiritual care department is to be notified within 60 minutes of a referral. Is the process designed and implemented to gather the identified elements?

Outcome measures focus on results. Did the completed process get the desired/expected outcome? Are provisions made to standardize, update, improve, and review outcomes? For example, is the chaplain meeting a patient’s spiritual or emotional need? What does the patient report? If a chaplain was called to comfort an anxious patient, did that person’s anxiety lessen?

Performance aligned with standards focuses on the measurable standards agreed upon across the profession. For instance, professional chaplaincy has [standards for certification](#) and standards of professional chaplains in [acute, long-term care, and hospice and palliative care](#). Does a chaplain’s performance meet those standards? How would a spiritual care department measure those standards? For instance, consider auditing a specific number of patient charts each month.

These three forms of measuring quality can work together. Spiritual care is an integral component of the palliative care team, so the process measure might be that palliative care initiates contact with chaplain upon patient admission within 24 hours. Performance aligned with standard might be that annually the palliative care team evaluates whether the chaplain’s performance meets standards 1 through 6 of the [Standards of Practice for Professional Chaplains in Acute Care](#). And the outcome measure might be that the chaplain tracks the number of palliative care patients seen, so that one could measure the variables in patients seen and not seen by chaplain.

In a non-acute care setting, perhaps the spiritual care department trains outpatient clinical staff on spiritual distress screening tools, so they can better identify spiritual and emotional distress that needs to be addressed by chaplains, thus generating spiritual care referrals. The process measure might be to report the number of staff trained in assessment, and the number of referrals made to spiritual care staff. The outcome measure might involve having the staff take pre- and post-tests that indicate level of comfort with detecting spiritual care distress. Performance aligned with standards might impose a standard that screening and referral tools and processes will be in place, with gradual training of all staff, such as year one 50%, year two 80%, year three 100%.

Early in 2014, the CHA Quality Subcommittee invited spiritual care leaders to share their experiences and practices with their spiritual care assessments in the electronic medical records. Participants included Beverly Beltramo, Oakwood Health System, Dearborn, MI; Carolanne Hauck, Lancaster General Health, Lancaster PA; Julie Houser, NYCHHC; Mary Lou O’Gorman, St. Thomas (Ascension Health), TN; Tim Serban, Providence Health and Services, OR; Mark Skaja/Amy Marcum, Mercy Health, OH; Mary Toole, St. Francis Hospital, Roslyn, NY, part of CHSLI; Mary Jo Zacher, OSF HomeCare Services, Peoria IL; Kay Gorka, Providence Health and Services, Spokane, WA; Matthew Kronberg, Dignity Health, California; and Richard Brochu, along with Sr. Marie Parker, VP Mission, Trinity Health. Gordon Hilsman, retired CPE supervisor, formerly with CHI Franciscan Health in Tacoma, WA, served as a consultant.

After a few meetings, we learned that we needed a common understanding of the *purpose* of spiritual assessments to share in broader publics. Some of the common understandings included:

- The practice is grounded in the dignity and wholeness of the human person.
- Identifying and addressing resistances to healing also affects the ability to cure.
- Providing to the interdisciplinary team quality spiritual assessment information offers insight into patient’s personal values, goals of care, and preferences for treatment, and how to communicate with the person regarding treatment options.
- If spiritual and religious emotional needs/distress are not addressed, it adversely affects choice of treatments, health outcomes, the patient experience, and the perception of quality care.

Also, we needed to articulate a common understanding of why spiritual assessments, including charting, should be integrated into EMRs. We agreed that:

- EMRs are the interdisciplinary team vehicle for information transmission, so the chaplain needs to contribute to it.
- One of the chaplain’s core competencies is capturing in words the present humanness/soul of the patient, thus contributing unique and vital knowledge.
- This information helps IDT members find direction as their discipline might recede toward futility, especially in some specialties, such as hospice, ICU, and palliative care.
- EMRs help clarify the chaplain’s mind and communicate to other chaplains who may subsequently encounter the patient.
- For the patient and family members (who activate their right to see medical records), these records summarize how the patient is being treated as a fine human being regardless of any difficulties s/he may be seen as causing.

Grounded with these two areas of common understanding, the group examined their common experience and practices through the lens of the three approaches to measuring quality.

The ***process measure*** identifies common elements that could become part of the spiritual care assessment. One could measure whether these elements were in place. The most common included:

1. Some assessment model, such as APIE (Assessment, Plan, Implementation and Evaluation) (www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/Thenursingprocess.html) or SOAP (Subjective, Objective, Assessment, and Plan) (www.emrsoap.com/definitions/soap/) that comprises core elements such as:
2. Types of intervention (initial/ongoing/crisis/sacrament/mediation/grief)
3. Connection with family
4. Religious affiliation
5. Connection with faith community — requests contact with faith community
6. Fear level (severe substantial, moderate, mild)
7. Ethical issues identified
8. Spiritual care interventions
9. Consult /referral to other services

Other elements that were not as common but considered important included:

1. Sense of holy/God
2. Peace/comfort
3. Spiritual strengths
4. Role of the faith community (meals, grief counseling)
5. Physical pain (hospice-centric)
6. Future care that included a brief narrative and types

7. A mutuality screen that was shared with and used by members of the IDT

Through the lens of measuring **performance aligned with standards**, one could first include the professional chaplaincy [standards for certification](#) (303.8, 304.6, 305.1) and Standards 1 and 3 of the [standards of practice](#) to measure their performance aligned with standards.

Three potential standards for spiritual care assessments within EMRs could be:

1. An SCA is in place with specific core content that includes:
 - Referral source/comment
 - Type of assessment/clinical encounter (e.g. initial, crisis, mediation, grief work, palliative care)
 - A specific assessment model (e.g. APIE, SOAP, SOAPIER)
 - Key interventions — perhaps top five (drop-down boxes) with specific and clear list available to chaplain, IDT, and others
 - Free-form narrative capability
2. The quality of the chaplain's SCA is measured by whether it:
 - Is available to all and in all settings
 - Is transparent to patients, colleagues, and care teams
 - Is patient-focused
 - Is IDT-inclusive (including complementary healing disciplines)
 - Employs clear, defined, common terminology (such as assessment, intervention, goals, outcomes)
 - Utilizes both assets and distress language
 - Includes common spiritual assessment categories (such as meaning, hope/peacefulness, concept of the holy); referral to others; community/support system; narrative/documentation; plan for future care
 - Assists in creating a spiritual integration network in each community
3. The quality of the narrative documentation is measured by whether the narrative:
 - Has a clear and mutually understood structure; e.g. Why were you called? Who was present? What were the interventions? How were the interventions received? What's the future plan?
 - Is understandable, concise, substantive
 - Is affirmed as helpful by IDT through feedback

Finally, for the **outcome measure**, the group suggested that one can measure by whether provisions are made for spiritual care departments to provide ongoing education on quality documentation, and for processes to continue to improve the SCA in EMR, including:

- Input of the IDT on usefulness of chaplain interventions and notes
- Designed and utilized criteria template for chart review, utilizing current chart review teams in quality departments
- A regular chart review by the spiritual care department and the IDT

If you are familiar with SCAs within EMRs, we hope you see the potential for identifying and utilizing specific measures for quality improvement that will help us improve our role on the IDT. Our group continues to learn from one another and look for others to join them in this important venture. If you have feedback or would like to participate, please contact David Lichter (dlichter@nacc.org).

How do you chart if the patient is reading your notes?

By Matt Kronberg

Imagine leaving a hospital room and then charting about the patient “not coping effectively with grief” after the recent loss of their spouse. An hour later you are called back and see the patient sitting up, iPad in hand, reading your spiritual assessment in the electronic medical record.

It could happen. The technology is here — and patients’ health information is in their control.

The patient is now a key member of our documentation audience, and we must adapt. With the emphasis on patient experience and caring beyond the hospital walls, we must consider what instant chart access means for spiritual care. Our audience has expanded to include patients and families, nurses and therapists, case managers and social workers, physicians and post-acute care specialists. This new ministry landscape holds many opportunities and challenges.

The work to improve spiritual assessments in the EMR is not easy. In recent years I’ve worked with spiritual care leaders and clinical informaticists in our system, and we have made great design and process improvements. But there is more difficult work to do. Reaching consensus among chaplains in diverse clinical settings, working within both budgetary and software limitations, and figuring out how to communicate across the continuum of care is a formidable challenge.

But I don’t wish to focus on the challenges. Instead I wish to foster a vision and begin a conversation, raising awareness about the importance of communication and design in our field. The iPhone highlights how design, technology, and communication are inseparable. It isn’t enough to learn the technology; we must learn the art of communication within the new medium.

The famous words of Marshall McLuhan remind us, and perhaps warn us, that “the medium is the message.” Our tablets and devices that are now linked to our EMRs convey a message to patients and shape their experience. A medium that allows the patient to immediately view a record of a very personal, and hopefully supportive, spiritual care assessment (accessible to dozens on the medical team) may not always be welcomed. Might spiritual assessments themselves — especially if not written and designed well — now cause a level of distress? It could be, but it does not have to be.

There is a “Seinfeld” episode where Elaine’s physician writes in her medical chart that she is “difficult.” After changing doctors, she is dismayed to see her new doctor frown as he reviews her old, recently transferred chart. Elaine is unable to escape one clinician’s judgmental assessment — an assessment that clearly didn’t enhance her patient experience. With this new technology, providing empathetic spiritual care for patients and families is not enough; now our EMRs and assessments must also communicate kindness and dignity.

Opportunities for Further Thought:

- A. How do we move our profession forward if EMRs don’t communicate nuance across the continuum of care?
- B. How do we balance many chaplains’ preference for narrative with challenge narrative presents in some research designs?
- C. How does real-time access to the EMRs affect design, narrative, and the visual representation of assessments? What impact might this have on professional training in spiritual care?
- D. What do we need to grapple with as a profession and as healing institutions to make spiritual care assessments that are professionally sound, effective, and safe?
- E. What design elements capture the nuances of a person’s culture and spirituality in electronic form? How might design improve both the patient’s health outcome and experience?
- F. Does the benefit of access to data for population health outweigh the value of patient privacy as we have understood it historically? What about spiritual privacy? How do we balance the need for a holistic approach to interdisciplinary communication with the vital need to maintain a relationship of trust, dignity, and kindness?
- G. How do we move beyond our spiritual care discipline and influence whole-person care among all clinicians? How can the EMR spur greater spiritual and emotional support for patients and families from physicians and other caregivers?

A chaplain mentor once told me, "Write your assessments as if the patient is reading over your shoulder." This image should guide us, encouraging us to ask: What are we communicating? Is it necessary? Encouraging? Useful for healing? Embracing new technology may lead to new approaches: ones that leave the patient with practical tools for spiritual growth, that encourage hopefulness, or that give a focus or new direction. The goal, as always, would be to enhance the well-being of the patient. Our visits and the spiritual assessments we leave with them (in the EMR and on their tablets) could ideally be key to their healing as they transition home.

This new landscape presents an opportunity to make a greater impact on the patient — to improve patient experience, enhance outcomes, and weave the influence of spiritual care throughout the continuum of care. In addition to using presence and conversation, prayer and sacraments, listening and kindness, we now have a medium that opens the possibility of real-time encouragement and spiritual influence.

As the Ethical and Religious Directives highlight, the foundation of a healing relationship is trust. In a world with so much distrust, how can we make spiritual assessments that both respect a patient's dignity and foster trust? Part of the answer is by improving how spiritual assessments are designed and used. I believe our charting should increasingly be characterized by:

- clarity, brevity, and professionalism
- empathy, dignity, and kindness
- sincerity, confidentiality, and acceptance
- being effective, encouraging, and educational

Progress in electronic charting is rarely fast — especially with the challenges before us. By focusing on design coupled with empathetically effective assessments, I believe we can make a larger impact. As health information shifts into the hands of the individual, my hope is that improving spiritual assessments will support healing, advance our field, and further our influence in the hospital and beyond.

Matt Kronberg, BCC, is director of spiritual care for the Dignity Health Central Coast Service Area in Santa Barbara County. A special thank you to the Rev. Tom Harshman for his contribution to this article.

System’s self-examination leads to better chart notes

By Kay Gorka

As chaplains, we are trained to be fully present, to provide nonjudgmental, confidential support, and to approach each patient without our own agendas. But historically, many chaplains have felt that charting undermines our values. As a result, at least in our hospital, the chaplains either did not chart or struggled to do it in a way that added value to the healthcare team. When our palliative care physicians audited charts, however, they identified multiple opportunities to improve the way chaplains documented spiritual assessments in the electronic medical record.

Our care facilities employ four staff chaplains in a community hospital of 197 beds and 12 staff chaplains in a 644-bed Level II trauma regional medical center that includes a children’s hospital. We partner with a palliative care team that includes four physicians, one nurse practitioner, two registered nurses, and one social worker. In November 2013, we began focusing on improving the quality of chaplains’ narrative documentation in the EMR.

Quality improvement requires awareness of the gap between where we are now and where we want to be. I recently watched a [TED talk by business professor Linda Hill](#) titled “How to Manage for Collective Creativity.” She emphasized there are three components needed in innovation: 1) creative abrasion — to amplify the differences; 2) creative agility — utilizing a scientific process and the creative process; and 3) creative resolution — combining opposing ideas. This requires action-reflection-integration, a process all too familiar to chaplains.

On our team, the creative abrasion began with amplifying three differences. First, the palliative care team requested that the chaplains write a well-organized narrative using a documentation tool. Second, the chaplains researched standard spiritual assessment tools for documentation and struggled to find an evidence-based tool that could be used in all clinical encounters. Third, the chaplains examined ways to integrate the [Standards of Practice for Professional Chaplains in Acute Care](#), in particular, Standard 1 — Assessment and Standard 3 — Documentation of Care.

The palliative care team sought to easily acquire the information necessary for a holistic care plan including the concerns and hopes of the patient, and the resources available. The palliative care team preferred the acronym HOPE (Hope, Organized religion, Practices, Effects on healthcare). Chaplains, however, had trouble using this model consistently.

- The model was hard to write to when ministering to patients/families in trauma situations, medical/surgical units, codes/crisis, and mother/baby units.
- Spokane is 60% non-churched, and mostly people would classify themselves as spiritual and not religious.
- Chaplains struggled to know where to write their interventions or care plan.

Instead of throwing in the towel, the chaplains entered into the creative agility phase. We began with the scientific method of establishing our objectives: 1) to develop a standardized model that would work for any chaplain, in any assignment across our two hospital campuses; 2) to articulate a quality spiritual care encounter in the EMR; and 3) to have the chaplains’ written documentation be of value to the interdisciplinary team.

The process took 12 months. I met with each chaplain once a month as well as held chaplain team meetings at each hospital on a monthly basis. I met with the palliative care director quarterly throughout the year. Each time, we would focus on two questions: 1) What worked when you charted using the HOPE system? 2) What were the barriers when you charted this way?

In addition, we audited 10 chart notes by each chaplain. We quickly found we needed a standard tool to conduct chart audits. We researched what others were using; in particular, the NACC quality workgroup informed the tool we developed:

<u>The quality of the chaplain EMR spiritual assessment meets these indicators:</u>	Y/N n/a	If :“no” Add Comment
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1. Assessment tool CARE for spiritual care is available		
1a. Clear, concise, substantive, understandable		
2. <u>Patient Focused:</u> Critical Information: Uses recommended pastoral care vocabulary to assess and describe the patient/family affect, disposition, and perception regarding:		
2a. Meaning		
2b. Hope/peacefulness		
3. Action of chaplain related to critical information, and indicators for intervention		
3a. Referral to others		
3b. Follow-up needed		
4. Resources: Includes both assets and distress language		
4a. Community/support system		
4b. Concept of the Holy, Divine, etc.		
5. <u>Interdisciplinary Team Focused:</u> Evaluation: Includes effects on healthcare, or recommendation		
5a. An increase in understanding of how this current medical event/crisis is impacting the overall life of the patient/family		
5b. Relaying observations unique to the chaplain role		

The second part of creative agility requires implementation of the creative process. After reflecting on the HOPE system, each chaplain developed a separate charting method, and we voted on one that best satisfied a chaplain’s need regardless of specialty or clinical area of practice. All our chaplains suggested improvements.

Finally, one of us collected the input of the chaplains and palliative care team, and then incorporated the standards of practice through an accessible format. All 16 chaplains at our two hospital campuses began charting with the same acronym for narrative documentation: CARE (Critical Information, Action, Resource, and Evaluation).

C	A	R	E
Critical Information	Action	Resources	Evaluation
What does the care team need to know about the patient/family?	What emotional/spiritual interventions did I provide?	What is the patient/family perception of support?	What is the impact of the patient/family spirituality on healthcare?
Referral source Observations:	<ul style="list-style-type: none"> ● Active listening ● Compassion-ate presence 	Internal sources: <ul style="list-style-type: none"> ● Attitude, 	<ul style="list-style-type: none"> ● Description of ongoing emotional/spiritual

<ul style="list-style-type: none"> ● Peacefulness ● Affect/disposition ● Persons present <p>Pt/Family statements about:</p> <ul style="list-style-type: none"> ● **Personalizing care/preferences ● Pain ● Personal/medical history ● Feelings/perceptions ● Primary concerns <p>*Including, but not limited to: language, reading ability, financial, or vision.</p> <ul style="list-style-type: none"> ● Faith/spirituality 	<ul style="list-style-type: none"> ● Exploration, validation, normalization of feelings ● Identification of primary concerns ● Life review ● Theological reflection ● Prayer ● Referral to care team 	<p>worldview</p> <ul style="list-style-type: none"> ● Values, faith, beliefs ● #Coping mechanisms <p>External sources:</p> <ul style="list-style-type: none"> ● *Surrogate Decision Maker ● Family, friends, neighbors *Including supportive relationships and difficult relationships ● Church/community ● Groups/clubs ● Hobbies, pastimes ● Counselor, therapy 	<p>needs</p> <ul style="list-style-type: none"> ● Recommendations to Chaplains/Care Team ● **Pt/Family preferences ● **Effects on Healthcare
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*Benefits especially the social workers

** Benefits especially the doctors and nurses

We immediately saw results. For example, when we started, the only time the palliative care team read the chaplain notes was during chart audits or if the team referred a patient to the chaplain. Now palliative care team members report that they consistently read chaplain notes before they enter patients' rooms. One palliative physician estimated that reviewing chaplain notes saves her 30 minutes a day, and chaplains are receiving more referrals from the palliative care team and from other healthcare professionals in the hospital.

In addition, healthcare professionals outside the palliative care team have told us the chaplain narrative notes help inform their care plan and that they better understand the individual needs of the patient.

Going forward, three recommendations were identified: 1) The chaplain must close the loop by thanking the interdisciplinary team member who made the referral. 2) Quality in documentation is ongoing for all healthcare professionals, and we will continue chart audits. 3) More collaboration outside of the palliative care team will be needed to determine whether this is a valuable model across hospital specialty areas.

As professional members of the interdisciplinary clinical team, chaplains have an opportunity to hone our process and the way we organize our documentation. The gap is narrowing between where we want to be as integrated healthcare professionals and where we are now at the two hospitals in our local system.

Kay Gorka, BCC, is manager of spiritual care services at Providence SHMC/HFH in Spokane, WA.

Entering the World of Charting and Spiritual Assessments

By Mary M. Toole

At our hospital, chaplains for many years were not allowed to write in patients' charts. For example, when a doctor had made a referral to pastoral care, or if there was a significant case, chaplains would ask the patient's nurse to document the presence and support of pastoral care. Like some other hospitals, every admitted patient was seen by a chaplain within 24 to 48 hours of their arrival. The chaplains as a group designed the paper assessment forms that were maintained in the pastoral care office. Updates were noted on these forms. But electronic medical records would be the start of our chaplains documenting in the patient's chart (standard 304.6 - see www.nacc.org/docs/certification/NACCStandardsOctober2013.pdf).

The directors of the pastoral care departments from the many acute care facilities within our organization met, and by reviewing samples, designed the screens that chaplains would use in the EMR system. As this was occurring, a committee of chaplains was formed at our facility to design a paper version of the main screen in preparation for EMR. We completed the assessment form for every patient and kept them in unit binders in the staff office. Chaplains were required to update the assessments after follow-up visits. The committee of chaplains completed a regular review of the assessments with a report indicating areas needing improvement. We shared a general review and observations with the staff without mentioning chaplains by name ([standard 305.5](#)).

As the time came to go live with EMR, our chaplains were looking forward to actually documenting in the patients' charts (standard 305.1 - see www.nacc.org/docs/certification/NACCStandardsOctober2013.pdf). We started by only using check-offs in all areas. Our assessments consisted of the following areas: clinical encounter, religious encounter, sacramental encounter, patient's spiritual encounter, family spiritual encounter, and advanced directives.

Each area contains multiple items for check-off responses; many of these check-offs allow for a comment to be typed. For instance, in "patient's spiritual encounter" there is an item *grief*. If the chaplain checked off any of the options for *grief*, a comment or brief explanation could be typed. If the chaplain marked "demonstrates grief often," the comment section could indicate the source of the grief; e.g., husband died last month. The completed grid of check-offs is inserted into the Notes section of our EPIC system, making the assessment viewable to all members of the patient's care team.

As we began charting in EMR, we were not writing narrative assessments because we needed further training. Most helpful to us was the two-part NACC audio conference held June 5 and 12, 2014 by Gordon Hilsman titled "Summary Point Charting for Interdisciplinary Effectiveness," and "Part II, Fashioning Summary Points."

A chaplain attending a conference brought back Chaplaincy Taxonomy by Advocate Health Care (www.advocatehealth.com/documents/AdvocateChaplaincyTaxonomy.pdf), which provided a list of suggested words to use for intended effects, methods, and interventions while writing a narrative statement.

To assist in writing quality narrative statements, all chaplains submitted a narrative statement for review. These statements were typed on one sheet of paper without identifying the chaplain. As a department, we discussed what was good/bad and how they could be improved. We then settled on five questions that should be answered in writing all narrative statements:

- 1) Why did you make the visit (referral, initial visit, crisis, follow-up)?
- 2) What was the patient/family issues that were discussed (specifics not necessary)?
- 3) What interventions were provided?
- 4) Patient/family response to the interventions?
- 5) What is the future plan?

The statements are to be brief and patient/family oriented (standard 303.8 - see www.nacc.org/docs/certification/NACCStandardsOctober2013.pdf).

We encouraged chaplains to follow this process in writing narrative statements in the Notes section of the EMR, making the assessment visible to all members of the patient's care team. We had our own quality review using our previous process. During this review, chaplains began to identify their narrative statements as they were discussed, sharing specific facts behind their narrative writing to help improve their writing skills.

Our staff chaplains' next step will be to ask our interdisciplinary teams for input (standard 305.2 - see [www.nacc.org/docs/certification/NACC Standards October 2013.pdf](http://www.nacc.org/docs/certification/NACC_Standards_October_2013.pdf)). Possible questions, taken from a presentation by David Lichter at the NACC conference, are: Do you read our chart notes? Do you find the notes valuable to your work? What about the note is meaningful to you?

This is an ongoing learning process for all members of the department, and together we will continue quality review of our documentation.

Mary M. Toole, BCC, is a staff chaplain at St. Francis Hospital, the Heart Center in Roslyn, NY.

Chaplain Encounters: Suffering child's compassion can teach adults

By Anne M. Windholz

Today a child screamed and cried in agony as his mother tried to help him go to the bathroom. Out in the hallway, the child life specialist looked at me.

"I'd wait about 15 minutes. He's been having a hard time."

A hard time. That's an understatement.

Diagnosed with lymphoma; undergoing surgery and recovering with bright hopes of going home for his birthday (his 10th!); and then the Sunday before that milestone, curling up on his hospital bed with crushing pain. Kidney stones. And then mouth sores. From the cancer treatments.

He can't go home. He refuses to eat. He won't talk. He hardly opens his mouth, because every touch of the lip, every turn of the tongue, is torture. Everything within cracked and ulcerated. I had thought he looked as sad as he could last week.

Until I saw him today. Skinnier. Paler. He sipped two spoons of broth from his mother's hand before pushing it away. His eyes shone like brittle ice, braced against the pressure of pain.

The intensity of his resistance seemed both instinctive and calculated. He was measuring steps across an icy pond. One wrong move and it would all break apart. If that happened, he might be sucked under and never come up again.

Panic sometimes cries loudest in silence.

His actual screams were terrible, however. Maybe because they were forced from him violently, as much against his will as the relentless emptying of his bowels. The screams of a creature in fear and pain. It struck me as I stood beside his door. I've heard those screams before, in the dusk: In South Dakota, when our cat caught and toyed cruelly with a baby bunny. We couldn't catch the cat quickly enough to save the bunny.

I spent time alone with the boy's mother. She told me about how her son never laughs any more. About how he doesn't want to move. And about how he made her cry.

"How?" I asked.

"He wouldn't talk at all yesterday. He would only whisper. I couldn't understand him — that felt so awful, forcing him to repeat what he'd said."

"What was he saying?"

"He told me to get his big sister a present."

"A present?"

"Yeah, he said she deserved one because she was suffering, too."

I used to be an English professor. When my own children were quite small, I researched representations of children and child abuse in Victorian children's literature. Two things struck me as I read evangelical religious tracts and morality tales in which "bad" children suffered horrible, horrible deaths.

The first was that at a time when childhood mortality was ubiquitous and pain relief was hit or miss, a great many children and their parents must have felt that God hated them.

The second was that all those sickeningly sweet childhood deaths in literature, which Dickens probably made most famous with Little Nell, were gross romanticism, offered up as a well-meaning but sentimental sop to comfort bereaved parents — which was practically everyone.

Call me a cynic. I had toddlers with tantrums pooping all over at the time. Plus I was a postmodern academic, and

sentiment doesn't go far with that crowd. So I thought saintly child deaths were all pretty much fiction. Bad fiction.

Fast forward 20 years.

. . . and I'm sitting in the pediatric family lounge with a mom who burst into tears yesterday at the wisdom coming from the wounded mouth of her boy, and I'm crying too. Crying partly because nothing I can do will stop the chill night from coming for this mother, but mostly because the reality is so amazing: Children, so fast at learning languages compared to adults, can equally outstrip adults in learning from suffering. In learning compassion for others.

Somewhere under the sentiment and the claptrap, the idealized Victorian child really was what children have always been: our wisest and best teachers. If we listen. If we are willing to bend down literally and metaphorically and be with them in their pain. Bear it with them. And respect what the poet Wordsworth observed: that these most vulnerable souls come into this world from God, "trailing clouds of glory."

What I bring to chaplaincy among the children I'm sometimes at a loss to say. But what it brings to me?

The pearl of great price. A millennium of lifetimes would not be enough to repay such a gift.

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Looking under the hood: Documentation of spiritual care

By Austine Duru

The patient is the focus of all forms of patient care. This fact is not lost on chaplains and healthcare providers who are challenged daily to provide the best care possible utilizing all resources at their disposal — one of which is documentation. A common phrase in chaplaincy circles is “If it is not in the chart, it did not happen.” Technology has facilitated electronic medical records as a standard practice. However, the art of crafting well-written chart notes is still very relevant, even at a time when medical records or patient charts are going digital.

Unfortunately, research into the effectiveness of documenting chaplain interventions in medical records (paper or electronic) is not as robust as research in other areas of chaplaincy care. A few key articles sum up the ongoing debate and development in this area.

Available early research on this topic focused on making the case for why chaplains should document their intervention. Notable among this earlier work is Rob Ruff’s “‘Leaving Footprints’: the Practice and Benefit of Hospital Chaplains Documenting Pastoral Care Activity in Patients’ Medical Records” in the *Journal of Pastoral Care*. Ruff, a chaplain, aims to establish a contextual framework to justify the relevance of charting. This coincides with a broader push across major chaplaincy organizations to include professional chaplains as integral members of the healthcare team. He identified three key reasons for chaplains to document their work: (1) Chaplains are integral members of the interdisciplinary care team. (2) Documentation will help create more visibility for the chaplain as a professional. (3) Documentation of spiritual interventions is proof of compliance with regulatory requirements by the Joint Commission to provide for the spiritual needs of all patients.

Ruff uses the SOAP (subjective information, objective information, assessment, and plan) method of documenting patient visit. This became a predominant model in chaplaincy circles for several years. This work is remarkable in its effort to encourage chaplains to adopt a stance of curiosity about their work — an initial attempt at evidence-based spiritual care.

A provocative article jointly published by Roberta S. Loewy, Ph.D., and Erich H. Loewy, M.D., in 2007 titled “Healthcare and the Hospital Chaplain” (www.ncbi.nlm.nih.gov/pmc/articles/PMC1924976) generated strong reactions from professional chaplains and healthcare providers alike. This article stirred the waters, and challenged the basic identity of professional chaplains and their role in the care of patients. At the root of Roberta Loewy (associate clinical professor) and Erich Loewy’s (professor emeritus) contention are patient rights to privacy and confidentiality, with a good dose of skepticism about what they called the “claims and assumptions of those involved in chaplaincy.”

Several articles have emerged since to reinforce the role of professional chaplains as an integral part of the interdisciplinary healthcare team, but with a critical eye to some of the concerns highlighted by Loewy and Loewy. One of these works merits our attention here.

Rabbi Rafael H. Goldstein and co-authors Deborah Marin and Mari Umpierre in 2011 published a research work in the *Journal of Health Care Chaplaincy* titled “Chaplains and Access to Medical Records.” The report studied how chaplains gain access to patient records and document their work across 44 large hospitals in the United States. Their findings support the practice of documenting chaplaincy interventions in patient records. It also led to an institutional decision at the author’s hospital to require chaplains to chart their interventions in patient record without extra credentialing, and pastoral care leaders were invited to help design, develop and pilot electronic medical records. This is a remarkable illustration of how research can support the practice of professional chaplains. This article is commercially available for a small fee at Taylor & Francis Online (www.tandfonline.com/doi/full/10.1080/08854726.2011.616172). A more thorough review could also be accessed at the ACPE Research Network (www.acperesearch.net/nov11.html).

David McCurdy’s “Chaplain, Confidentiality and the Chart” (www.professionalchaplains.org/files/publications/chaplaincy_today_online/volume_28_number_2/28_2mccurdy.pdf) is another substantive article on this topic. While not a research project, it offers an ethical dimension on the challenge of charting in chaplaincy interventions in patient records. In reference to Loewy and Loewy above, McCurdy offers a nuanced view on documentation, patient rights, and confidentiality, and suggests it is vital for chaplains to reflect on how they use and share protected health information. McCurdy’s extended examination of confidentiality lays the foundation for a normative framework that chaplains and

institutions may use to address documentation and confidentiality issues. The principles and value priorities that follow may inform chaplains and institutions' approaches:

1. Identify and prioritize the values and interests at stake, putting the patient's interests first.
2. Respect and appreciate the potential sacredness in what the patient communicates and document accordingly.
3. First, do no harm.
4. Inform patients that chaplains document and are open to discussing what this means.
5. Apply the need-to-know test thoughtfully.
6. Ask "What would I want — and not want — disclosed to the health care team if I were this patient?" (McCurdy, 2012).

Another article, "Measuring Spiritual Care with Informatics" by Burkhardt and Androwich, offers a perspective from nursing research around documenting spiritual care. Their aim is to apply the theory of informatics to aid in the development, design, execution, and evaluation of chaplain interventions. In the [July/August 2009](#) issue of *Vision*, Burkhardt shares a case example from Loyola University Health System in an article titled "Informatics: Capturing and Measuring Spiritual Care."

Today, more data is available, coinciding with the push to capture an accurate and complete record of patient care. Major chaplaincy organizations have adopted documentation as an important standard of practice. With documentation comes the possibility to review, measure, and improve the quality of care. More research by professional chaplains and collaborators is needed to support the requirement for chaplains to share their encounter and intervention with the interdisciplinary care team, while focusing on the specific need of each patient.

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CPE students learn to see charting as part of ministry

By Marika Hanushevsky Hull

Like most of us called to chaplaincy, chaplain interns in the CPE program are ready and open to care for patients, and see electronic charting only as a necessary evil. But in teaching CPE students about electronic charting, I try to emphasize two things: that charting is part of professional interdisciplinary practice, and that charting is part of the continuing spiritual care of the patient in the permanent medical record.

Some of the essential and practical aspects of charting that are covered in CPE training are: the meaning and ownership of the medical record; the legal limits of charting, and the legal implications of charting and not charting; avoidance of medical terminology; avoiding legal snares; the reasons for charting and criteria for what not to chart; tips for effective charting; conciseness and distinguishing objective from subjective data. In this article I will primarily touch on the reasons for charting and on conciseness in charting.

CPE provides training for charting according to the objectives outlined in the ACPE handbook and the Common Standards of our profession. Although different forms and formats are used in different institutions, the kind of information that is communicated is similar. Like texting, Facebook, or instant messaging, electronic charting has its own unwritten rules for format and type of information. The most important bits of information are the date, time, and duration of the visit, the patient's religious preference, the reason for the visit, and comments.

Date, time and duration are set. Religious preference is straightforward if the patient is of a mainline denomination or faith tradition. Many patients who say they have no religious preference, might, after conversation with the chaplain, describe themselves as spiritual but not religious, or of no particular religion. For these patients one suggestion is to enter: "Religion not specified." It is a respectful way to leave the conversation open for the patient, and to signal to other spiritual care providers that the patient is open to discussion of spiritual needs or concerns.

The reason for the visit is a tricky area to maneuver. The information on the chart is permanent. If a patient or family member should request a copy of the medical record, would they want "grief," "relationships," "God," "faith and hope," "discouragement" to be part of their permanent record? Is it best to maintain the confidentiality of the conversation, and to signal the need to another team member in the record only with the patient's permission, or if the chaplain feels that it is necessary for the care of the patient? This is a pastoral question and decision. Any comment that could possibly shame the patient should not be made in the record. Of course, mandated reporting of child or elder abuse or suicidal ideation do not fall under discretionary documentation, and must be reported by the chaplain according to their hospital protocols and policies.

What to say and how to say it is also an area of concern. The space for comments on the electronic chart can be a choice of boxes to be checked or a drop-down menu with limited space for typing. Even though there may be no technical limit on the words you can write in the box, the electronic rectangle itself gives an instant visual limit. If another team member clicks the note box and has to scroll down too far, you will lose your reader. Twenty-five words or so, or whatever will fit easily into the space, is a good goal. Typing in all caps is easier, so that you do not have to think of upper and lower case. Keeping abbreviations to an absolute minimum also helps to make the message clear. For example, "PT" for patient, "CH" for chaplain, and "DR" for doctor are easily recognizable.

A chart note is also a way to speak to a particular audience, whether it is the nursing supervisor, the physician, the occupational therapist, the next chaplain on call, or even the patients themselves or their families. Most importantly, it communicates the singular contribution of spiritual care to the patient's healthcare team. Charting is a way for chaplains to hone their pastoral practice and assessment framework, to provide a brief time for reflection on the visit, to choose whom the chaplain is "messaging."

Charting is not just a chore at the end of a visit or an already long day. It is an integral part of pastoral practice in healthcare settings. It is a way for chaplains to continue to care for the patient in the permanent record. Professional practice as guided by the objectives and outcomes in CPE training and as required in the Common Standards of chaplaincy is an ally and an aide to pastoral care in the patient record.

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Assessment tool helps evaluate chart notes

By David Lewellen
Vision editor

When Carolanne Hauck and Beverly Beltramo couldn't find a tool to assess the quality of spiritual care notes, they developed one of their own.

No consensus has yet developed around best practices for charting, and "just because we think we're doing it well doesn't mean we are," Beltramo said. But last year, she and Hauck were separately looking for a more empirical method when they connected as part of an NACC work group about electronic medical records. Together they developed a matrix that rates a chaplain's note in three broad categories: spiritual assessment, implications for care, and narrative. (A sample note, and the matrix assessment of it, are shown below.)

In active use, Hauck said she has found that "chaplains tend to put in too much rather than not enough." Beltramo said, "Narrative is a challenge, making sure that it says what it needs to say while still being reasonably brief."

Beltramo used the matrix in monthly department meetings, choosing a note at random and leading a discussion over where it fell in the various boxes of the grid. (The author of the note has the option of remaining anonymous during the discussion.) Hauck has used it in training and in discussions of what makes a good chart note; it serves as a concrete example for people for whom charting is a growing edge for what their peers see as quality work. "We're all on this journey together," she said.

Hauck is the director of chaplaincy care and education at Lancaster General Health in Pennsylvania. Beltramo is currently chief mission officer at St. Joseph Mercy Oakland in Michigan.

Practically, a good documentation that hits all the necessary points can be invaluable for a colleague making a follow-up spiritual care visit, and it can also help doctors and nurses. "It can be long and detailed, but not long and rambling," Beltramo said. "Sometimes there's a lot of nuance in what we hear from the patient, and if we can capture that," others are grateful.

Hauck said that frequently, palliative care notes are longer, "because the other members of the team need more. ... We're willing to do what's most helpful to the staff."

However, both chaplains sounded cautions about diving too deeply into the medical portion of a chart. "You could spend a day reading a 40-page chart and not have the depth of understanding," Beltramo said; more often, the chaplain can learn the essentials by talking to the nurse on duty. "She really knows the patient and has a clue how we can be the most helpful," Hauck said.

In noting outcomes and results, Beltramo cautioned that "in a 20-minute visit, the patient's not going to be, 'Oh, I'm happy now.'" Chaplains "need to learn to be OK with that. Sometimes it's enough that you're present to whatever it is."

Seven Narratives for Chaplain Charts

By Gordon J. Hilsman

The quiet dispute over whether chaplains could beneficially learn to use narratives in their charting notes emanates at least partly from some spiritual caregivers' difficulty in imagining patient situations in story form. As a partial remedy, consider these seven kinds of stories that hospitalized people often experience and share with chaplains and other caregivers. When shared in medical record notes with interdisciplinary team members, any one of these stories might foster greater team awareness of spiritual needs, and of the healing that can take place around them.

The story of hospitalization: Some stories of the very process of how this person became hospitalized remain unknown to some IDT members. When there are colorful aspects that are shared in brief detail in a chart note, the patient becomes more boldly visible to those who read the note. That patient becomes more uniquely human to IDT members, enriching a bit the interpersonal culture of hospital care.

The story of *the reason* for hospitalization: People tend to share how their serious condition occurred or developed over time. They may do this more fully with a chaplain who lingers with them in dedicated listening than with busy clinicians. What is unique about any of these stories, and what seems to be the particular focus of the person as she tells it, may be quite significant data for both nurses and medical practitioners.

The story of attitude: A person's feelings about his condition and its treatment are likely to be of particular interest to physicians. This was true even before "the patient experience" and patient satisfaction became an additional motivation for careful medical practice. Many doctors know that attitude toward one's medical condition affects healing, although how is not yet well understood.

Stories of medical events: The simple story of how a person reacted to recent events in her medical saga is likely to also be of interest to the professionals caring for that person. Changes in attitude, motivation, or decision-making, perhaps illustrated by a patient quote, may be of particular use to treatment team members.

Stories of family events: What is happening of either joy or worry in the lives of one's family members can suggest a succinct story, in one sentence or less, that paints a picture of this person as real and striving for bits of happiness — warmth, love, pride, relief, hopes, or resolutions — wherever they can be found.

Stories of regrets: The "mother of all spiritual needs" is still regret — in the forms of guilt, shame, hurt, or regret over what one has done or endured that continues to return unpleasantly to consciousness even years later. Writing down people's stories of regret, whether remorseful confession or humiliating abuse, can be intricate as a chaplain scampers along the line of confidentiality. But if that chaplain wants to be part of the umbrella of confidentiality under which IDTs function, she must contribute to it as well. Finding general terms with which to record these as significant spiritual events in this person's life further solidifies team members' awareness of how complex personal healing can be.

Stories of brushes with transcendence: Experiences of awe on the one hand, and dread at impending tragedy on the other, shape one's very spirituality. They etch themselves into our memories and influence our attitudes toward the unmanageable and unfathomable aspects of human experience. Hospitalization seems to precipitate both the experiences themselves and sharing them with a relatively objective person dedicated to the care of people's spirit. Stories in well-chosen words that convey the profundity of such experiences to caregivers remind those professionals of the value of their own work. Such stories also are likely to increase their professional satisfaction.

Hyper-verbal accounts of what has transpired between patient and chaplain quickly become burdensome to clinical practitioners. But summary sentences, succinctly conveying the current state of the human spirit of that person, hit home in the hearts of IDT members. Fashioning narrative chart notes that achieve that end remains an art and probably always will. It is an art worth developing.

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