Who reads our Progress Notes?
And really, why should they?

Jerry Kaelin / NACC Chaplain & ACPE Supervisor
NACC 2016 National Conference / “Making All Things New”
Chicago, IL / April 22-25

“Make no small plans.”
Daniel Burnham / 1846-1912
1909 Plan of Chicago

“Chicago ain’t ready for reform.”
Paddy Bauler / 1890-1975 / Alderman of 43rd Ward
His salute in his saloon at news of Richard J. Daley’s election as Mayor of Chicago in 1955
Scrutinizing Our Spiritual Care (and our Notes)

“Scrub-scrub-scrub? What else do you want? Do you want to take my shorts. Give me a break...Go scrutinize yourself. I get scrootened every day, don’t worry, from each and every one of you. It doesn’t bother me.”

--Response of Mayor Richard M. Daly on August 28, 2011 when ask about increased family scrutiny if his brother, Bill, were to step down as Obama’s Chief of Staff to run for Governor of IL

“Make no small plans....”

Spiritual Care is coming to be highly valued in some quarters of medical care, particularly among Palliative Care inter-disciplinary teams, e.g.,

“Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus”


See: www.gmhas.org

“The business of Medicine ain’t ready for a reform that will...”

• ...fully embrace and integrate spirituality in care of whole person – despite major emphasis on “patient experience” and patient satisfaction scores.

• Significant elements of the ACA ain’t going away anytime soon, no matter what happens in our 2016 election

• Huge and present administrative fear about reimbursements in light of the changes demanded by ACA

• Cut-backs of Spiritual Care staffs

• More dependence on CPE students or uncertified part-time chaplains vs. fully certified staff chaplains

• But in fairness: No money, No mission
As a result of this workshop, and accompanying scrutiny, participants will:

1. Learn a model for Spiritual Care Progress Notes that is grounded in and speaks to the medical model of SAIOP:
   - Subjective / Assessment / Intervention / Outcome / Plan
2. See how this model operates in the EPIC EMR at Loyola University Medical Center.
3. Practice writing a Progress Note in this model, based on a few provided patient/family scenarios.
So, what’s it going to take to plan large and re-form our work?

Who reads our Progress Notes?
And really, why should they?

Who are we writing for?
- Medical team, not each other as chaplains.
- Some format for communication between chaplains; later, Loyola’s “Tier Book”

What are we writing?
- A clear and succinct summary of facts and meanings useful to the medical team, usually regarding spiritual distress and it’s actual or possible impact on medical care.
  - Narrative (the story!) usually in five sentences or less! Medical team doesn’t have time for more...
  - Data as discrete (& continuous variables) is for Administration — and research

When do we write (vs. just click administrative data)?
- All visits demand some documentation. “If it wasn’t charted, it didn’t happen.”
- Many, even most visits do not warrant a Progress Note. Later, a list of which visits do demand a Note at LUMC

Where do we write? (Which EMR program do you use?)
- Is the Spiritual Care documentation in your EMR integrated into and accessible to medical team?
- Does it meet your goals?
- Do you have access to IT Team to change or adjust your Spiritual Care section of your EMR?

Why are our Progress Notes so important?
- We sometimes have an essential contribution for the medical team, as we all treat the whole person.

How might we...
- Re-imagine, re-image, re-structure our Progress Notes: some ideas from this workshop...
Chicagoland’s Loyola University Health System is a member of Trinity Health

Loyola University Medical Center campus
--550 beds in Maywood, IL hospital
--11 ICUs, 40% of patient population
--Highest acuity in stat of IL
--550 Faculty & Attending physicians
--645 Resident and Fellow physicians
--1900 RNs
--Also on campus:
  - Stritch School of Medicine
  - Niehoff School of Nursing
  - Bernardine Cancer Center
  - Loyola Outpatient Center

LUMC, as a Level One academic medical center is unique (the odd duck) in the Trinity system

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 21 states from coast to coast with 90 hospitals, and 120 continuing care locations — including home care, hospice, PACE and senior living facilities - that provide nearly 2.1 million visits annually.
Loyola’s EPIC charting system:

--Created from scratch in 2003 by teams from Loyola and EPIC
--Ongoing changes, expansions, improvements
--Pastoral Care department worked with Loyola nursing faculty
Lisa Burkhardt, RN & PhD in informatics

1. EPIC Doc flowsheet:
   --**Discrete** variables: # visits with pt or family; # pre-op visits, codes, deaths, etc.
   --**Continuous** variables: 12 Patient Encounters and 5 Family Encounters
   --**KEY:** “Spiritual Distress” (1-5) row shared with nursing doc flowsheet;
     Nurses see chaplain rankings and chaplains see nurses ranking
   --**DATA:** Good for reports and work flow for Administration
   --Buried in EMR; no one would ever take the trouble find it to look at!
   --A goldmine of discrete and continuous data, never excavated in research!

2. Progress Notes
Patient Spiritual Encounters Derived and Adapted from the “Systematic Nomenclature of Medicine, Clinical Terminology” (SNOMED CT)

Each encounter is ranked as a continuous variable: 1-5 (“worst” to “best”)

1) Spiritual Distress: Severity of spiritual distress is evidenced by difficult coping, emotional suffering, feeling fear, anger, guilt, grief loss and alienation from people, relationships, religion, God: inquires about prayer or seeking spiritual connection.
2) Child Adaptation to Hospitalization: Adaptive response of a child age 3 thru 17 to hospitalization
3) Suffering Severity: Severity of anguish associated with a distressing symptom, injury or loss that has potential long-term effects
4) Fear Level: Severity of manifest apprehension, tension, or uneasiness arising from an identifiable source
5) Anxiety Level: Severity of manifest apprehension, tension, or uneasiness arising from an unidentifiable source; often involving some cognitive aspects, expressed as uncertainty
6) Loneliness Severity: Severity of emotional, social or existential isolation response.
7) Hope: Optimism that is personally satisfying and life-supporting
8) Coping: Personal actions to manage stressors that tax an individual’s resources
9) Social Interaction Skills: Social interactions with persons, groups or organizations.
10) Grief Resolution: Adjustment to actual or impending loss
11) Dignified Life Closure: Personal actions to maintain control during approaching end of life
Family Spiritual Encounters Derived and Adapted from the
“Systematic Nomenclature of Medicine, Clinical Terminology” (SNOMED CT)

Each encounter is ranked as a continuous variable: 1-5 (“worst” to “best”)

1) **Family Coping:** Family actions to manage stressors that tax family resources

2) **Family Normalization:** Capacity of the family system to maintain routines and develop strategies for optimal function when a member has a chronic illness or disability.

3) **Family Participation in Professional Care:** Family involvement in decision-making, delivery and evaluation of care provided by health care personnel.

4) **Family Support During Treatment:** Family presence and emotional support for an individual undergoing treatment.

5) **Caregiver-Patient Relationship:** Positive interactions and connections between the caregiver and care recipient.
LUMC EPIC Pastoral Care doc flowsheet:
2. Progress Notes – a lightening bolt

Who are we writing for?

Progress Notes are **primarily** for the medical team, not other chaplains. Our “Spiritual Distress” row does communicate and integrate us with nurses. Let’s not **silo** ourselves, talking to one another when we already do talk to one another.

(Later we realized we needed documentation for shift changes and continuity of care and we created a “Tier Book” which ranked chaplain follow-up into tiers.)
**BUT who reads our Notes at LUMC?**

At Loyola, the LUMC EPIC programmers (and Risk Management) can tell who opens a chart, but not who opens any particular individual section, like Progress Notes.

In an informal and unscientific survey, 6 of 11 staff chaplains asked about 20+ of our colleagues if they looked at our Notes. About half responded of the asked nurses (ICU and floor), social workers, case managers and physicians responded positively.
Who *really* reads our Notes at LUMC?

Those asked were members of the healthcare team that chaplains worked with and felt comfortable asking. More of the ICU workers responded positively than the floor staff with comments like:

--Your Notes help us to understand our patients spiritual distress, fear, suffering & joys.
--Without your note, I would not have known she was struggling with despair related to prognosis and family disagreement with pt choice of comfort care only.
--The chaplain Notes tell the story of the patient…the emotions and spirit.

Medical ICU: 3 nurses concurred that they only look when pt or family in extreme distress

On a general surgery floor: 2 nurses 50% of the time; 2 nurses 20%; 2 nurses 0%

In Surgical ICU: 2 nurses 50% of the time; 3 nurses 30-50%; 1 nurses 0%

Two neonatal ICU: 2 nurses rarely read chaplain’s Notes; SW always

Neuro ICU: 6 nurses, all the SW and one attending all chimed in an enthusiastic “Yes.”
What are we writing?

And if we wrote “better” (more helpful to their work), would word spread and more of our colleagues read our Notes?

• **WE must make it worthwhile for a nurse or doctor** to expend their precious time and energy to open and read our Progress Notes.

• Our Notes should **impact** medical staff’s care.

• A clear and succinct summary of facts and meanings **useful to the medical team**, usually regarding spiritual distress and it’s actual or possible impact on medical care.
  • Narrative usually **in five sentences or less**!
  • The “story: captured in a pt/family subjective quotation
  • Medical team doesn’t have time for more...
  • Data as discrete (& continuous variables) is for Administration – and research

• **This is a skill that can and must be learned!**
What can we write differently?

-- Workshop Learning Objective #2

Use the medical model:

• **SUBJECTIVE** quotation from pt and/or family
• SPIRITUAL **ASSESSMENT** at beginning/during the visit
• SPIRITUAL **INTERVENTION** – pastoral response
• SPIRITUAL **OUTCOME** – at the conclusion of the visit, what difference did chaplain make?
• SPIRITUAL **PLAN** for follow-up
SUBJECTIVE quotation

• From SOAP note format

• A quotation from patient and/or family
  o Focused on PATIENT EXPERIENCE.
  o This is **the foundation** for assessment and a key “hook” for medical staff.
  o This summarizes the narrative
  o This captures and succinctly encapsulates “**the story**”
Spiritual Assessment

• 1-3 synthesized statements of pt/family spiritual issues or needs
• Gaged and appraised in this visit, with empathy, with intuition and based on observable behavior and non-verbals
• Always checked out and confirmed (to avoid chaplain’s projection)
• Cleveland Clinic “still”
“Could a greater miracle take place than for us to look through each other’s eyes for an instant?”
--Henry David Thoreau

Too shocked to understand treatment options.

Five years cancer free.

Wife had a stroke.
Worried how he will take care of her.

One still adapted from The Cleveland Clinic video

“If you could stand in someone else’s shoes and
Hear what they hear,
See what they see,
Feel what they feel,
Would you treat them any differently?”

At LUHS, would you chart your Spiritual Care Progress Note any differently?
Spiritual INTERVENTION

• How chaplain responded
• What chaplain did

• **Verbs:** Chaplain listened, supported, prayed, encouraged, explored, empowered, consoled, advocated, challenged, discussed, facilitated, offered, addressed, elicited, reinforced, articulated, consulted, notified, recommended, responded to assessed need, etc.
Spiritual OUTCOME

• 1-3 synthesized statements of the results of spiritual care for this pt/family during this visit

• What difference did it make that the chaplain was there?
  o We occasionally help people change their lives, find themselves and find God
  o We sometimes facilitate discovery of new insights, resolve, resiliency and connection
  o We often transform 5, 10, 15 minutes of a patient’s day
  o We (almost) always show compassion and care
  o We are changed ourselves for our day’s work and ministry
Spiritual PLAN
• Indicated follow-up, referral, availability if needed

In the format of LUMC’s EPIC EMR Progress Note the recorded doc flowsheet Patient and Family spiritual encounters (issues assessed and addressed) are automatically transferred and “dumped” into the Progress Note.

The succinct narrative sentences specify the general issues assessed and addressed in this visit

See next page EPIC screen shot.
A Progress Note in LUMC’s EPIC EMR

**Subjective:**
Pt. "I'm very frightened because I've never had surgery before, but I'm hopeful for a full recovery."

**Spiritual Assessment at beginning of visit:** Pt fearful related to 1st surgery; hope related to faith in surgeon and God's presence

**Spiritual Intervention:** Provided emotional/spiritual support for fear and Prayed for hope in surgery and God

**Spiritual Outcome at end of visit:** Fear reduced; hope strengthened

**Spiritual/Emotional Distress:**
- Moderate
- Fear Level: moderate
- Hope: often demonstrated
- Coping: sometimes demonstrated

**Spiritual Plan:** Pastoral Care provided referral to fear; will follow post-op
Kaelin, Jerry, BOARD CERTIF  
Pastoral Care  
Signed

**SPRITUAL CARE PROGRESS NOTE**

Jerry Kaelin, BOARD CERTIF, Loyola pager #92037; Gottlieb Vocera #538-4000

**Type of Spiritual Care visit:** Pre-Op visit

**Subjective:** Subjective: Pt. "I'm very frightened because I've never had surgery before, but I'm hopeful for a full recovery."

**Spiritual Assessment at beginning of visit:** Pt fearful related to 1st surgery; hope related to faith in surgeon and God's presence

Spiritual Distress: substantial
Fear Level: substantial
Hope: often demonstrated
Coping: sometimes demonstrated

**Spiritual Intervention:** Provided emotional/spiritual support for fear and Prayed for hope in surgery and God

**Spiritual Outcome at end of visit:** Fear reduced; hope strengthened

Spiritual/Emotional Distress: moderate
Fear Level: moderate
Hope: often demonstrated
Coping: sometimes demonstrated

**Spiritual Plan:** Pastoral Care provided referral to fear, will follow post-op
To Progress Note \textit{or not to} Progress Note? that is the question...

At LUMC, “Progress Notes” are required and written by staff chaplains (and co-signed for students) for these categories:

- nursing or other medical team referral (EPIC, pager, or verbal)
- every ICU visit – even a simple “pt intubated, prayed” – the doc flowsheet ‘dump’ make this easy & it documents PC’s contention that a vast majority of our time is spent in crisis visits...not helpful for medical staff, so a “Type of Visit” titled: \textit{Spiritual care visit SIGNIFICANT for medical care}
- pre-op (EPIC from nurse or Loyola next-day Surgery List)
- follow-up Palliative care visit
- trauma
- cardiac or respiratory code
- death or dying patient
- any floor visit that warrants a Note
- Many visits do \textit{NOT} get a Progress Note, only documentation in doc flowsheet
Tier Book instead of Progress Notes for Spiritual Care department communication, chaplain to chaplain, shift to shift for continuity of care

The “Tier Book” is the LUMC PC department’s internal and informal process for indicating patients and/or families who warrant follow-up, based on both medical and spiritual acuity:

- Whom are we following?
- Why are we following these patients / families?
  - What are their assessed pastoral needs?
  - What assessment did you enter in doc flowsheet and/or in Progress Note?
- What should I be aware of pastorally? What do you want me to do in the follow-up visit?
- Record what I actually did back in Tier Book and give directions to the next chaplain, noting any change in assessed needs. Or not.
Practice writing a Progress Note in this model, based on a few provided patient/family scenarios.

--Workshop Learning Objective #3

• Read the pastoral scenario on next slide

• Go to Slide #8 and assess the pt’s spiritual need(s) using one or more of the Patient Encounters, ranking 1-5.

• Two slides ahead, use the SAIOP format to write a 5-7 sentence narrative to capture the specifics of this situation using the format outline. Remember, you are writing your Note for the medical staff.
A pre-op visit

Generated from the “next day surgery list” to the on-call chaplain during the 1pm-9pm shift. Chaplain knew that it was an 84 year old female, Roman Catholic, scheduled for open heart surgery to repair a valve. Chaplain knocks on the door and enters the room and approaches the patient.

P1: Come in and who is it?

C1: Hello, my name is Kathleen, I am here this evening to visit with you. I am one of the chaplains doing pre-operative visits and from my list I have you listed for surgery tomorrow morning. Is this correct?

P2: Yes, this is correct and I am glad you are here to see me. Pull up a chair and sit next to me. I do not have that great of eyesight so sitting close helps me to see your face.

C2: Fine, I am glad to visit with you. How are you doing?

P3: I am fine with the surgery; that is not what I want to talk with you about is that ok?

C3: Sure, you sound concerned about something, what is it you would like to talk with me about?

P4: I want to be sure that what I tell you is confidential and it stays between you and I. Can you do that for me?

C4: I can keep confidential what you share with me and I need you to know that there are several issues that I would not be able to keep confidential. (Pt interrupted chaplain)
P5: What I am going to tell you has nothing to do with taking someone life or my illness; it has to do with relationships.

C5: That’s fine....

P6: I have been married for over 60 years to the same wonderful man and there is something I have been carrying in my heart for those many years. When we were in the early years of our marriage, my husband went overseas for the war. I was a young mother, scared and our families were on the west coast and I was in Chicago with a new baby and my husband far away. I was young and stupid and it did not mean one thing to me...but I was lonely and I had a one night relationship with a man who was our next door neighbor...a bachelor. I regret it, I went to confession and I never ever repeated this behavior again.....Do you think God has list of all the good I have done with my family and my husband since that one indiscretion?

C6: You have been carrying this for 60 years and even though you have done good things, went to confession, and have lived a good life with your husband you are still struggling for peace with it?

P:7 Yes, I cannot go to surgery tomorrow without knowing that my God remembers the good and forgives my sins.

C7: What you have shared with me this evening is most sacred...and it is a conversation of which our God is a part of and through your words and asking for peace I believe in a merciful and forgiving God that has always been with you. What would help you prepare for surgery tomorrow?

P8: A prayer that includes my asking for forgiveness and thanking God for the blessings in my life. I am grateful for all that I have been given. (Patient began to pray and chaplain joined with her. I shared communion and a blessing for surgery).
C8: I will see your family in the surgery waiting area tomorrow and I will make sure to follow-up with you after your surgery. Are you feeling peaceful at this time?

P9: Yes, I feel ready to go to surgery, not burdened and I thank you for allowing me to share this very personal issue of my life.

C9: You are most welcome and it was my privilege.

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Next slide is Lisa Burkhart, PhD, RN summary page of reliability and validity of 68 chaplains at 2010 Association of Professional Chaplains assessing this vignette (and two others).

++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

• Go to Slide #8 and **assess** the patient’s spiritual need(s) using one or more of the Patient Encounters, ranking 1-5.

then

• Use the blank SAIOP model on slide 29 to **write** a 5-7 sentence narrative to capture the specifics of this situation using the format outline. Remember, you are writing your Note for the medical staff.
### Psychometrics of Documenting Spiritual Care

**Lisa Burkhart, PhD, RN; Marie Coglianese, MPS, BCC; Jerry Kaelin, MA, MDiv, BCC**

**Loyola University Chicago and Loyola University Health System**

#### Introduction

As health systems adopt and design electronic health records, health care professionals are creating electronic data repositories that can be used to support research and evidence-based practice. To support this research, documentation screens need to be designed to optimize validity and reliability. Historically, nurses have not documented spiritual care, and chaplains have not been required to document. Now spiritual care is a Joint Commission requirement [1]. Past psychometric research has supported measuring spiritual outcomes on 5-point Likert scales [2,3]. This poster will present findings from a pilot study that evaluated the reliability and validity of 12 individual and 5 family NOC [4] and SNOMED CT standardized spiritual terms among chaplains.

#### Methods

At the American Association of Professional Chaplains annual meeting in 2010, 68 chaplains participated in a research study to measure the reliability and validity of spiritual care outcomes using three vignettes of chaplain-patient encounters (15 men, average age 55, 92% Caucasian). Vignettes were designed to reflect a change in patient spiritual outcomes after chaplains provided spiritual care. Vignettes were developed by professional chaplains and content and face validity were supported by 5 expert chaplains prior to the workshop. Each vignette was acted out by the participants during the workshop, lasting approximately 10 minutes each. Chaplain participants completed two identical surveys to document patient spiritual outcomes before and after spiritual care was provided per vignette. Each survey tool listed the spiritual outcomes, which included definitions of each term and a 5-point Likert scale (1 was the least desirable and 5 was the most desirable outcome). Reliability was measured using percent match compared to overall mean. Validity was assessed using change scores per vignette to discriminate expected change.

#### Results

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**Descriptive statistics indicate non-normality with kurtosis being more than the consecuitive ordinal values.** This supports interrater reliability. For example, in Vignette 1, the mean value of Spiritual Assessment before spiritual care was provided was 1.35, and findings indicated that 98% of participants rated spiritual assessment as either “1” or “2” on the Likert scale. Change scores were all significant, supporting discriminate validity.

#### Conclusion

It is possible to document spiritual outcomes after a 10-15 minute patient encounter using Likert scales, accurately and consistently. These findings can support research in spiritual care.

Epilogue and Assessment

Patient died in surgery. Chaplain went to the family after the patient had died.

Husband 1: I know you were with my wife last night. And she was so grateful for your visit. Did she tell you anything that I should know?

Chaplain 1: Smiling... She told me that she had loved you for over 60 years and you were a blessing in her life.

The scenario writers assessment issues: in visit / at conclusion of visit:

- Spiritual Health  2/4
- Suffering Severity: 1/4
- Fear Level: 2/4
- Hope: 3/5
- Coping: 3/5
- Social Interactions Skills: 5/5

Your assessment?
Type of Spiritual Care Visit: Pre-op

Subjective: Patient quotation

Spiritual Assessment at beginning of visit: Succinct summary of specifics of general doc flowsheet

Dump from doc flowsheet:
- Spiritual Distress: 2
- Suffering Severity: 1
- Fear Level: 2
- Hope: 3
- Coping: 3
- Social Interactions Skills: 5

Spiritual Intervention:

Spiritual Outcome at end of visit: Succinct summary of specifics of general doc flowsheet

Dump from doc flowsheet
- Spiritual Distress: 4
- Suffering Severity: 4
- Fear Level: 4
- Hope: 5
- Coping: 5
- Social Interactions Skills: 5

Spiritual Plan:
Some sharing of **impressions** of the experience of writing a Note in the SAIOP model...How different from your home EMR model?

Questions?
Comments?
Ideas?
Suggestions?

• I continue to learn and develop this Note writing skill.

Thanks for your attention and participation!
Make no small plans for re-forming Spiritual Care!