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

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 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 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.”

BARRIERS

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
... Barriers to Chaplain Documentation

- 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... 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 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: “With the IDT’s encouragement...”

Documentation Wording with Erroneous Implications

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:

Why have you been dinged?

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

**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:** Longs for a sense of Providence
...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
A Thesaurus for Spiritual Care

- Observation
- Intervention
- Outcome

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:
  - Pastoral dialogue
  - Reflective conversation
  - Spiritual Reflection
  - Faith Expressions
  - Conducted Ritual
  - Provided Blessing

- Ministry of Presence
- Prayed for _____
- Read Scriptures for _____
- Educated about ___
- Projected imagery of afterlife
- 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.

Others???

Please feel free to forward other ideas for the Spiritual Care Thesaurus to:
Byendor@AOL.com

Give yourself credit for the good work you do by documenting your spiritual care to the patient and family!
Many thanks to
Rev. Diane Datz, RN,MA
Hospice Program Director
HealthCare ConsultLink
for her insightful contributions to this presentation.