Spiritual Health Victoria

DOCUMENTING SPIRITUAL CARE IN PATIENT MEDICAL RECORDS:

A BEST PRACTICE RESOURCE

Spiritual care: Creating more compassionate, person-centred health care

Introduction

The aim of this resource is to provide information and procedures for the documentation and recording of health information by spiritual care practitioners working in health services in Victoria. This resource was reviewed and updated January 2018.

Background

Accurate documentation in medical records is integral to the care provided by spiritual care practitioners in health services. Documentation may be used for communication between health professionals, assessment, auditing, legal or research purposes. Patients or clients may also request information from their health records. To meet best practice, spiritual care practitioners must ensure that they are aware and adhere to their existing health service's protocols, standards or procedures as well as current legislation for documenting in patients' health records (Spiritual Health Victoria, 2016a). This resource will aid in achieving this objective.

Definition

Documentation includes medical records, whether a written or electronic record, audio, video, emails or any records relating to a particular patient that may be used for communication, assessment, auditing, clinical, legal or research purposes. (Victorian Healthcare Association, 2009)

In Victoria, the Health Records Act 2001 regulates the collection and handling of health information:

> "The Act applies to the health, disability and aged care information handled by a wide range of public and private sector organisations. This includes health service providers, and also other organisations that handle such information." (Health Vic, 2001)

Purpose of Resource

The purpose of this resource is to provide guidance in the best practice of documenting spiritual care provision. It meets the Victorian, national and international industry standards including:

- *Spiritual Care Minimum Data Set Framework* (Spiritual Health Victoria, 2015)
- *Spiritual Care in Victorian Health Services: Towards Best Practice Framework* (Spiritual Health Victoria, 2016a)
- *Capability Framework for Spiritual Care Practitioners in Health Services* (Spiritual Health Victoria, 2016b)
- Spiritual Care Australia's *Standards of Practice* (Spiritual Care Australia, 2014)
- *A National Code of Conduct for health care workers* (COAG Health Council, 2015)
- *Standards of Practice for Professional Chaplains (USA)* (Association of Professional Chaplains, 2015).

It can be used in the following ways:

- Training and formation of all spiritual care practitioners
- Guiding quality improvement in documenting spiritual care
- Meeting legal and professional requirements and standards
- Providing a structured and standardised approach to spiritual care documentation for patients in health services.

See Appendix 1 for full details of the alignment with Victorian, national and international standards.

General Principles for documentation

(Adapted from *Client Record Documentation in Community Health: VHA Clinical Governance in Community Health Discussion Paper* (Victorian Healthcare Association, 2009).

General principles for documenting spiritual care include the following:

1. Entries are made in the **Progress Notes** and the patient is identified by using a BRADMA label or including the following minimum Patient identification details:
    a. Patient's full name
    b. UR Number
    c. Date of Birth
2. Entries are **contemporaneous**: that is, a record is made at the time of the appointment or as soon as practicable after the appointment
3. Entries are **chronological**: entries are made at the time that it occurs. If a late entry is made, it is filed in chronological order and marked as a "late entry"
4. Entries identify the **discipline** which has provided the intervention: use a Pastoral/Spiritual Care sticker or print PASTORAL/SPIRITUAL CARE clearly with a box around it
5. **Date and Time**: the date and time of the entry is recorded using a 24 hour clock after the spiritual care visit. If the entry is made at a later time, this needs to be noted
6. The entry **is clear, accurate, concise and complete**
7. The **intervention** used and a future care plan if appropriate is the first item recorded in the entry. The Australian ICD-10-AM/ACHI/ACS Spiritual Intervention Codes are used to identify the intervention
8. The entry uses **objective** language using generic descriptors of the issues discussed (see Appendix 2). This provides additional information to staff and enables optimum patient care (Ziegler, Harriet & Moore, Danni, 2016) (Breguet, 2017). The patient's own words are inserted in quotation marks when recording **subjective** data
9. **Structure**: The entry is structured according to an approved method of documentation such as **SOAP, PIE, NIR or ISBAR** (see Appendix 2)
10. If the intervention is as a response to a **referral**, this is clearly documented in the record and the referral source is identified
11. **Corrections**: errors are not removed from the health record: a single line is drawn across any errors and the correction is initialled and dated by the person making it
12. The entry is **legible**
13. **Signature of the recorder**: the spiritual care practitioner completes the entry by signing using the first initial, surname, status/role and date
14. **Colour of pen**: a black or blue pen is used to ensure that the documents are clear if photocopied or scanned

15. **Abbreviations**: Individual health service's standard abbreviations are used so that these can be interpreted correctly by all professionals involved in patient care.

ICD-10-AM/ACHI/ACS Spiritual Intervention Codes

The Spiritual Intervention Codes are used in all spiritual care documentation as per current standards.

It is important to only use the title of the Code (not the numbers) and to document one code per intervention.

The current Spiritual Intervention Codes from the ICD-10-AM/ACHI/ACS, Tenth Edition are:

Block [1824] Other assessment, consultation, interview, examination or evaluation

96186-00 Spiritual assessment

Initial and subsequent assessment of wellbeing issues, needs and resources of a client. This intervention can often lead to other interventions.

Includes:

- informal explanatory dialogue to screen for immediate spiritual needs including religious and pastoral issues
- the use of formal instrument or assessment tool

Block [1869] Other counselling or education

96087-00 Spiritual counselling, guidance or education

An expression of spiritual care that includes a facilitative in-depth review of a person's life journey, personal or familial counsel, ethical consultation, mental health support, end of life care and guidance in matters of beliefs, traditions, values and practices.

Block [1915] Other client support interventions

96187-00 Spiritual support

Spiritual support is the provision of a ministry of presence and emotional support to individuals or groups.

Includes:

- companioning of person(s) confronted with profound human issues of death, dying, loss, meaning and aloneness
- emotional support and advocacy
- enabling conversation to nurture spiritual wellbeing and healing
- establishing relationship
- hearing the person(s) narrative

96240-00 Spiritual ritual

All ritual activities, both formal and informal.

Includes:

- anointing
- blessing and naming
- dedications
- funerals
- meditation
- memorial services

private prayer and devotion
public and private worship
rites
sacraments
seasonal and occasional services
weddings and relationship ceremonies

Block [1916] Generalised Allied Health interventions
95550-12 Allied health intervention, spiritual care

Recommended Methodologies for Documenting Spiritual Care

There are many professional methodologies for structuring medical record documentation. A health service may already use an approved, preferred structured narrative style or an acronym as a structure for documentation.

Spiritual care practitioners need to be oriented and educated in a consistent and agreed methodology which is used by everyone in their department and accepted by the health service. (Glenister, 2011)

Below are examples of some of the recognised methodologies:

1. **SOAP** is a method of documentation that is commonly used by healthcare professionals from many disciplines. As this is recognised across professional healthcare disciplines, this method is highly recommended.

   Subjective observation describes how the patient feels about or perceives their situation.

   It comes from the patient's self-report. It is information that does not have independent or external validation. When possible it is best to use the patient's own words in quotations.

   It can also be information about the patient given by someone else that cannot be verified.

   Objective observation is information gained by direct observation by professionals, clinical examination, data collection etc. This information can be independently verified.

   Assessment refers to the professional conclusions from reviewing the subjective and objective observations.

   Plan describes how the practitioner intends to address the specific problems identified. (Kagle, 2005)

2. **PIE**

   Problem - the patient's issue which the spiritual care practitioner is addressing.

   Intervention - what care was provided?

   Evaluation - the patient's response to the intervention. (Burkhart, Coglianese, & Kaelin, 2011)

3. **NIR**

   Need - what was the referral or need of the patient?

   Intervention - what did the spiritual care practitioner do or what went on with the patient or their family?

   Response - what response did the patient or family have? (Hull, 2011).

4. **ISBAR** (Note: in some Victorian health services this methodology is only used for verbal communication and handover, however in others it can also be used in written documentation. Before using ISBAR, confirm the practice in your health service)

   Identify - Who you are, your role, where you are and why you are communicating.

   Situation - What is happening at the moment?

   Background - What are the issues that led up to this situation?

   Assessments - What do you believe the problem is?

   Recommendations/risk - What should be done to correct this situation? (Clincal Governance, Hunter New England, NSW Health, May 2009)

Competency in Documenting Spiritual Care for Practitioners in Training

Professional spiritual care practitioners require training in documentation and data collection during their formation and practice. Hilsman reminds practitioners of the skill required and the importance of charting when he points out that charting is an "art" and that patient notes are legal documents (Hilsman, 2009).

Spiritual care practitioners are oriented to the documentation requirements and practices of the health service and the spiritual care department as part of their orientation process. During both training and ongoing practice, a spiritual care practitioner is monitored and reviewed for their competency in documentation.

When new to a health service, an experienced practitioner's competency in documenting is reviewed and evaluated to ensure that they comply with the agreed methodology in their new workplace.

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APPENDIX 1

Alignment to Victorian, National and International Standards:

The Documenting Spiritual Care in Patient Medical Records: A Best Practice Resource is aligned with Spiritual Health Victoria's Frameworks and national and international industry standards. The relevant standards for documentation are:

Spiritual Care Minimum Data Set (SCMDS) Framework, Spiritual Health Victoria (Spiritual Health Victoria, 2015)

> *A contact by a Professional Practitioner would meet all the following criteria:*
> *…… Requires a dated entry in the medical record of the Patient/client using an ICD-10-AM/ACHI/ACS Spiritual Intervention Code* (Australian Consortium for Classification Development, 2017).

Spiritual Care in Victorian Health Services: Towards Best Practice Framework, Spiritual Health Victoria (Spiritual Health Victoria, 2016a)

> *Accurate and consistent data collection and record keeping by spiritual care practitioners is an essential part of the accountability of a Spiritual Care Department in its delivery of spiritual care……*
> *Professional practitioners document patient visits in patient notes and medical records in accordance with the health service's policies and SHV Spiritual Care Minimum Data Set Framework* (Spiritual Health Victoria, 2015) *and SCA Standards of Practice* (Spiritual Care Australia, 2014) *(p.16).*

Capability Framework for Spiritual Care Practitioners, Spiritual Health Victoria (Spiritual Health Victoria, 2016b)

> *Domain 1. Provision of Care*
>
> *1:1 Performing healthcare activities*
>
> *1.1.1 Plan and Prepare*
> - *Collect and record information in a timely manner, ensuring it is relevant to the patient/client spiritual needs (p.9)*
>
> *1.2 Supporting processes and standards*
>
> *1.2.3 Information Management*
> - *Maintain accurate, up to date, and legible records according to established data collection and local guidelines (p.15)*

Standards of Practice, Spiritual Care Australia: **Standard 4: Accountability & Standard 9: Continuous Quality Improvement** (Spiritual Care Australia, 2014)

> *Standard 4: Accountability: Record details of spiritual care delivery, client preferences and outcomes of care into individual's care records and databases as required.*
> *Comply with organisational policies and regulatory guidelines regarding privacy and confidentiality (p.11).*

Standard 9: Continuous quality improvement: "Collect relevant data to monitor the quality and effectiveness of spiritual care (p.16).

A National Code of Conduct for health care workers, Appendix 1- Recommended clauses for a first National Code of Conduct, (COAG Health Council, 2015) p.77:

15. Health care workers to keep appropriate records: 1) A health care worker must maintain accurate, legible and up-to-date clinical records for each client consultation and ensure that these are held securely and not subject to unauthorised access.

Standards of Practice for Professional Chaplains, (Association of Professional Chaplains, 2015)

Standard 3: Documentation of Care: The chaplain documents in the appropriate recording structure information relevant to the care recipient's well-being.

APPENDIX 2

Template for Documenting Spiritual Care		
Attach BRADMA sticker at top of new page		
Pastoral/Spiritual Care **Date:**	**Time** (24hr)**:**	
ICD -10 - AM/ACHI/ACS Spiritual Intervention Code (Use code title and use one only)		
Document Referral, Assessment, Intervention, Outcome and Plan using a structure e.g.:		
Subjective Observation		
Objective Observation		
Assessment		
Plan		
Or		
Problem		
Intervention		
Evaluation		
Or		
Need		
Intervention		
Response		
Or		
Identity		
Situation		
Background		
Assessment		
Recommendations		
Future Care Plan:		
Name (first initial, surname)**:**	**Signature:**	**Status/role:**

Example of Documenting Spiritual Care
BRADMA sticker with UR Number
Pastoral/Spiritual Care **Date: 8/1/17** **Time: 12.30**
Pastoral /Spiritual Assessment
Referral made by L. Williams, Midwife (Thank you)
Subjective Observation: Jane talked to her midwife and requested a baptism for her stillborn baby girl at 20 weeks. The midwife reported that Jane and her partner, James, were distressed and wanted a baptism as soon as possible.
Objective Observation: The Spiritual Care Practitioner met Jane and James who were both crying. Jane expressed her sadness and that she wanted to leave the hospital as soon as possible. Jane and James are practicing Christians. A naming and blessing ritual was discussed. The ritual was co-created with Jane and James for baby, Jennifer Louise to be conducted at 13.30 pm.
Assessment: Jane and James were relieved to discuss and plan for the naming and blessing ritual for Jennifer Louise.
Plan: Spiritual Care Practitioner will put together the naming and blessing ritual and create a ritual booklet. She will conduct the naming and blessing ritual for Jennifer Louise at 13.30pm. A copy of the ritual booklet, a candle and a Naming and Blessing Certificate will be given to Jane.
Or
Problem: Jane delivered a still born baby girl at 20 weeks gestation. She and her partner, James were both distressed. She expressed to the midwife that she wanted a baptism for her baby as soon as possible. The midwife contacted the Spiritual Care Department to request a baptism for Jane's baby.
Intervention: The Spiritual Care Practitioner met Jane and James who were both crying. Jane expressed her sadness and that she wanted to leave the hospital as soon as possible. Jane and James are practicing Christians. A naming and blessing ritual was discussed. The ritual was co-created with Jane and James for baby, Jennifer Louise to be conducted at 13.30 pm.
Evaluation: Jane and James were relieved to discuss and plan for the naming and blessing ritual for Jennifer Louise.
Or
Need: Jane delivered a still born baby girl at 20 weeks gestation. She and her partner, James were both distressed. She expressed to the midwife that she wanted a baptism for her baby as soon as possible. The midwife contacted the Spiritual Care Department to request a baptism for Jane's baby.
Intervention: The Spiritual Care Practitioner met Jane and James who were both crying. Jane expressed her sadness and that she wanted to leave the hospital as soon as possible. Jane and James are practising Christians. A naming and blessing ritual was discussed. The ritual was co-created with Jane and James for baby, Jennifer Louise to be conducted at 13.30 pm.
Response: Jane and James were relieved to discuss and plan for the naming and blessing ritual for Jennifer Louise.
Future Care Plan: Spiritual Care Practitioner will put together the naming and blessing ritual and create a ritual booklet. She will conduct the naming and blessing ritual for Jennifer Louise at13.30pm. A copy of the ritual booklet, a candle and a Naming and Blessing Certificate will be given to Jane.
Name: P. Smith **Signature:** **Status/role:** Spiritual Care Practitioner

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