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Creating and Implementing a Spiritual / Pastoral Care Plan

Rabbi Stephen B. Roberts, MBA, MHL, BCJC; Chaplain D. W. Donovan, MA, MS, BCC; and Rev. George Handzo, MDiv, BCC, CSSBB

A spiritual screening tool completed by a nurse indicated that a patient had specific chaplaincy needs. The request for a professional chaplaincy consult was provided to me with no other information other than it was urgent. When I entered the room I noticed how young Sarah was, in her late thirties or early forties. Next to her bed was a picture of herself, a man her age, and a child. Sarah was dying. During our visit she asked me to visit her daughter, Rebecca, who was also currently hospitalized in the same facility. They both had an extremely rare genetic disease, which Sarah only learned about after the birth of Rebecca. Sarah was end stage, and Rebecca was now in the early stages of the disease. Rebecca was only twelve years old, and this was her first hospitalization. It would turn out to be Sarah's last. I met Abraham, the husband / father, at Rebecca's bedside when I went to visit. I also met Terach and Kitura, one set of Rebecca's grandparents, who were at her bedside as well.

Planning is an important part of our lives. We go to the supermarket with a plan—a shopping list; we drive with a plan—a map; if we are from a liturgical tradition, we worship from a plan—a prayer book. Good planning ensures that we remember the important things and also reach our goals in life.

Yet, chaplains are often resistant to using spiritual / pastoral plans that clearly document assessed spiritual / pastoral issues regarding the patient / resident / family, state goals that we desire to see accomplished based upon the assessed needs, then provide clear interventions and expectations about the interventions, and finally document outcomes based upon the interventions. Even worse, chaplains rarely work to ensure that their plans are fully integrated into the overall plan of care created for the patient / resident. Many chaplains' chart notes are not read because they do not include information useful to the team, including a plan that helps the entire team provide better care to the patient and family.

The focus of this chapter is how to help the reader contribute to the overall plan of care through effective documentation. This chapter is intended to provide specifics on a spiritual / pastoral care plan; discuss how they might differ based upon the institution; explore and provide examples of spiritual symptoms; and discuss in detail the spiritual / pastoral care plan sections that focus on goals and then on interventions that are developed from the goals and that lead directly to expected outcomes related to the goals.

Key Assumptions

The Association of Professional Chaplains' *Standards of Practice for Professional Chaplains in Acute Care Settings* states the first assumption: "The chaplain develops and implements a plan of care to promote patient well-being and continuity of care."[1] We thus assume that all current and future professional chaplains, plus those who educate chaplains, will be interested in developing and implementing expert care plans done on par with the work of other health care departments, such as social work, dietary, physical therapy, medicine, and so on.

The second key assumption is that the spiritual / pastoral plan of care is an integral part of the overall plan of care. Thus, when creating a care plan, the chaplain needs to differentiate between the more general spiritual care sections in which the whole team participates, in particular helping with spiritual screening and history, and the "professional chaplaincy" care sections, which are the specific part of the plan that the professional chaplain does: spiritual assessment, goal setting, and spiritual interventions.

> We support the idea that spiritual care is everyone's job on at least two levels. As caregivers who have our own spiritual dimension, we should be relating to our patients and their loved ones on this level. Furthermore, every professional caregiver, while each has a specialty on the health care team, needs to have an awareness of and a concern for the whole person—physical, emotional, social and spiritual. For example, the chaplain needs to be able to recognize and generally evaluate suicidal ideation, both to be able to pass on this information to those on the team whose job it is to respond to it, and to be able to then properly interpret and treat the depth of the patient's spiritual distress. Spiritual assessment should be a part of a patient's overall assessment by their primary care physician, along with assessment of the physical and psychological domains.[2]

The final key assumption is that there is a difference between spiritual care, which anyone on the team can provide, and "chaplaincy" care, which only a trained clinician in spiritual care can provide (i.e., spiritual assessment, goal setting based upon stated spiritual issues, and then appropriate spiritual interventions). Rev. George Handzo writes in chapter 3:

> The professional board certified chaplain is the spiritual care lead on the health care team. This does not mean that the chaplain is the only one to do spiritual care. It does mean that the chaplain is the spiritual care specialist who oversees the spiritual and religious component of care and is the subject-matter expert for the rest of the team.

With this final assumption is the strong caveat that professional chaplains are responsible for finding ways *and* training the larger team on how to do spiritual screening and provide spiritual care appropriate to their training and skills set. On this second subject our colleague Chaplain Kristopher P. Zygowiec writes the following in *PlainViews*:

> At this time we ask ourselves this question: how can each of us contribute to creating a caring environment for all, regardless of our individual responsibilities? One way is by communicating to our guests that we are comfortable and open to assisting them with the ritual of prayer, if requested. How can we do this in a sensitive way, leaving complete control in the hands of the patient / guest? The words which were shared by a friend: "WOULD a prayer BE HELPFUL?" fulfilled that purpose. We created ID badge tags.... This ID badge tag is available to all members of the St. Helena

> Hospital Region team whether they have direct contact with our clients or not. At the end of every orientation, I often have a few people asking for this tag. As I share the principle of a supportive prayer, I point to the back of the tag where they can read the sample of a short prayer: "Dear God, In times like this we are thankful to place our faith and trust in You. We ask for hope, healing, and peace in Your loving care. Amen." The response has been very positive, and the members of the staff (from Environmental Services to our doctors) who feel comfortable with being asked to pray by our clients are also beginning to wear this tag with their ID badge. In a hospital setting, the chaplain does not have unilateral access to the patients and caregivers. That access is shared by the whole team which is responsible for creating a healing environment, and the number-one spiritual intervention that is requested—a prayer—plays an extraordinary part in it. A similar approach can be implemented in every health care institution (not only faith-based) which takes spirituality seriously.[3]

We know this is a controversial topic, especially in facilities where there is not a standard practice / operating procedure. We had a long discussion about this topic ourselves. While Chaplain Zygowiec's approach represents one option, that option might not be acceptable or advisable in all settings and requires a good bit of oversight and ongoing training by the chaplaincy team. We encourage all departments to have an open discussion with the entire range of stakeholders about this topic. Quality improvement projects are one way to investigate and standardize within your facility. Strategic planning using outcome oriented chaplaincy projects is another approach to this topic.

Plans of Care Should Be Specific to Your Type of Institution

The Psalter found in the Hebrew scriptures includes 150 different psalms. Why? One psalm does not fit every occasion. Nor does one type of care plan fit all institutions. Many health care systems now include acute care (adult and pediatric), behavioral health, hospice, and long-term care within the range of services they offer. Care plans for medicine, social work, nursing, and so on look different within the different lines of service. Our care plans must also accurately reflect the type of chaplaincy we specifically provide, based upon location and

service line. There is great commonality, but there are also great differences. In setting up professional, replicable, explainable, and consistent spiritual / pastoral plans of care, each type of line of service needs one specifically crafted for it. There will be overlap between the plans, but there will also be unique features to each plan. Our challenge, as a profession, is to consistently craft these plans so that when our professional colleagues working in other departments move from institution to institution but remain doing the same type of work, they will be able to instantly recognize and feel comfortable with the spiritual / pastoral care plan at the new institution.

Only a Detailed Spiritual Assessment Leads to a Plan

I met extensively with Sarah, Rebecca, and Abraham. After a thorough spiritual assessment, it became clear that each member of this family had their unique profound spiritual issues that required professional chaplaincy attention. The assessment also indicated that each person also had more general spiritual needs that could be met by the larger staff.

There is a major distinction between a spiritual screening and spiritual assessment. A screening is a basic tool that can be done by any member of the professional team. In chapter 3, Rev. Handzo writes:

> The screening should, at minimum, evaluate how important religion and spirituality are to the patient's coping, how well those coping strategies are working at the moment, and whether the patient has any immediate religious or spiritual needs that require chaplaincy care intervention. The success of the referral system depends on the ability and willingness of non-chaplaincy care clinical staff to reliably do spiritual screening.... We recommend a screening system developed by George Fitchett, which has been shown to have a high reliability in identifying spiritual distress.

An assessment, on the other hand, can only be done by a trained professional chaplain. In particular, as stated in chapter 3:

> The assessment should elicit information that will lead to a profile of the patient's spiritual and religious resources and needs, and *a plan of care* with interventions and expected outcomes. (italics added)

The Plan

First, all plans need to be clear. This is essential so that the information within the plan is understood by members of the team when they refer to it. Remember, our plan will be referenced numerous times when we are not present to answer questions. Second, our plans must be fully and completely incorporated into the larger care plan. This is one way we integrate with the rest of the team—and thus become integral to the overall care plan. Finally, the plan needs to indicate who is responsible for what actions. Without this, no one is responsible for the action. Plans must lead to accountability.

A chaplain who is fully integrated into a larger care team may feel that documenting a plan of care is too time-consuming and even redundant. Such a chaplain would likely have spoken with the relevant physician as well as the nurse caring for the patient. But a health care team taking care of a single patient can easily include twenty or more people, all of whom may benefit in some way from your assessment.

This leads to the second point: documentation must include both your professional assessment of the relevant issues and clear "take-aways" for your colleagues. Consider the following example:

> ***Follow-up with patient and husband:*** *Upon my arrival, both were crying. As we explored their unfolding grief, Abraham noted that he was embarrassed to feel sorry for himself. He spoke of feeling overwhelmed with the prospect of being a single father to Rebecca. He has granted me permission to share this information with the treatment team, whom he feels are often insensitive and make comments that presume the bulk of the work will be done by other women in the family.*
>
> ***Plan:*** *Chaplain will continue to explore this issue with family. Nurse manager will speak to issue with care team members tomorrow, and it will be discussed as a part of rounds the day after.*
>
> ***Recommendations:*** *Although the cultural background of many of our staff is matriarchal, it is important to avoid projecting these assumptions onto this family. Special attention should be given to involving the father in any and all conversations that involve the daughter. This has been discussed in particular with Social Work in terms of helping him plan (emotionally and*

practically) for the discharge of his daughter in the context of making end-of-life plans with his wife.

A good plan helps all team members know what is expected of them (they have clarity). Further, it focuses each person who has responsibility for any part of the plan. Focus leads to a productive use of time by all team members, as each person becomes deliberate about what they must do and by when.

Symptoms and Issues Assessed

I could have easily written "spiritual distress" for both Sarah and her daughter Rebecca. Yet, that would not have helped me or the staff address their specific spiritual / pastoral issues. Rather, Sarah's assessment in the care plan included: "(1) Sarah is feeling overwhelming guilt related to her impending death, thus depriving her daughter of her time and her guidance, as well as feeling guilty for having passed the genetic illness on to her. This guilt is causing great upset for her and her husband. (2) As the only child of Holocaust survivors, Sarah is also struggling with the deep loss her parents are feeling. This hospitalization has opened old spiritual wounds around loss for the whole family. Sarah feels this spiritual struggle is preventing her from focusing on herself and her daughter. (3) Finally, Sarah is currently unable to comfort her daughter, who is hospitalized for the first time with the same genetic illness. The daughter is being treated in the PICU."

When a patient / resident is suffering physical pain, it must be documented in the care plan. The person assessing the situation will include the pain's location, amount, onset, and any other issues related to the pain. Only then can the plan continue with treatment. Similarly, it is not enough just to write "spiritual distress" as a spiritual assessment. The documentation must be more extensive. It should be able to include the following:

- What exactly are the spiritual / pastoral issues assessed that need treatment?
- How long have the various issues been going on (did it start as a result of this hospitalization / illness or was it there previously)?

- What is most likely causing each issue?
- How does the issue impact the patient / resident and his or her care?

These bulleted concerns must be clearly included in the care plan. They need to be comprehensible, concise, and understandable by both the chaplains and others who read the chart.

Figure 5.1 lists a sample of spiritual / pastoral symptoms and issues that might come up in an in-depth assessment that should be documented.

While this list is extensive, it is not complete. Different situations will include different issues. For example, someone working in a pediatric intensive care unit might document, "Sibling guilt leading to sibling not wanting to visit" or "Sibling despair as he / she feels helpless and unable to support loved one and what he / she is going through. The patient is thus feeling isolated and in need of support." Someone working in a hospice environment might document, "Spousal spiritual / emotional exhaustion leading to cutting down on visits, leading to patient feeling abandoned" or "Unfinished family issues that patient is spiritually struggling with, causing great spiritual distress." Someone in a long-term care facility might document, "Spiritual loss brought on by loss of independence and private residence. Resident has indicated this loss is leading to feeling sad, gray, without joy, and a distance from God."

Each facility should work from a consistent list developed for their specific type of work. The consistency of assessment will allow other professionals to understand the issues that we assess and address. This also helps them make appropriate referrals to our department when they notice specific issues that we are trained to address.

Goals

> ***Goals for Sarah:*** *(1) Help Sarah and her husband feel less overwhelmed by spiritual issues of guilt. Help her to directly concentrate on her concerns to help in this goal. (2) Help Sarah to focus more on herself by helping her and her family address the multigenerational spiritually struggles around loss this illness is bringing up. (3) Help Sarah find ways to comfort her daughter, Rebecca, who is currently in the PICU.*

Goals come before interventions. Goals are destinations we seek to reach for the patient / family we are working with. They are based upon

EXAMPLES OF SPIRITUAL / PASTORAL SYMPTOMS AND ISSUES THAT SHOULD BE DOCUMENTED

- 12-step and spirituality
- Abandonment
  - By family and friends
  - By God
  - By religious community
- Anger
- Courage—spiritual
- Courage to change
- Denial
- Depression—as a spiritual illness
- Faith
- Forgiveness
  - Toward God
  - Toward others
  - Toward self
- God / Higher Power
- Grief / loss
- Guilt
- Hope
- Hopelessness / despair
- How spirituality helps in healing
- Illness as identity / living with chronic illness
- Loneliness
- Love
- Meaning / meaninglessness
  - Of illness
  - Of life
  - Of world
- Peace / peace in adversity
- Prayer / meditation
- Punishment
- Reconciliation
- "Recovery"
- Redemption / renewal
- Relationships
- Repentance
- Rituals and symbols
- Sanctification / sanctity of life
- Serenity
- Sin
- Spiritual emptiness
- Suffering
- Suicide
- Temptation
- Transitions / change
- What is religion?
- What is spirituality?
- Wonder, awe

Figure 5.1

the assessed and documented needs, which should come prior in a care plan and which they should reference. The interventions then become the specific tools we use to help all involved reach the destination. Goals need to be specific so they are both "measurable" and leave us "accountable." Goals need to clearly state:

- Spiritual issue being addressed.
- Who should be doing this? (Assumption is the chaplain. When it is not the chaplain, it must be clearly stated who should be working on the issue.)
- Measurable outcome (sometimes stated and sometimes implied).

Sarah's first issue, as documented in the care plan, was not guilt. Rather, it was Sarah's sense of being overwhelmed by the guilt. The specific care plan goal was to help her feel less overwhelmed (not less guilty). It was specific and measurable. In future conversations, staff members, whether from chaplaincy, social work, and / or medicine, can assess and then document whether she states she is feeling the same, less, or more overwhelmed by the "guilt related to her impending death, thus depriving her daughter of her time and her guidance, as well as feeling guilty for having passed the genetic illness on to her."

One way to assess is a closed-ended question such as by a social work colleague who is supportive of our mission: "You mentioned to the chaplain that the guilt you were feeling was overwhelming you. I see in the chart that [*intervention described*]. Has the feeling of being overwhelmed by the guilt lessened, stayed the same, or increased?" The nature of this closed-ended question is a measurement in relationship to a goal. Further, by the specific nature of the goal we are held accountable in a similar way to someone who is treating physical pain.

The second goal is to help Sarah be able to focus on herself. Multigenerational loss is the spiritual issue that needs to be addressed. If we are successful, then we, or any member of the care team, will be able to assess and document that Sarah feels she is better able to focus on herself at this time. Again, by the use of a closed-ended question, one can make this determination. Think of the pain chart test. Using one through nine, the patient / resident indicates how much pain he or she is feeling at that moment. Checking the chart allows the caregiver to know whether the pain is more or less. A specific question that any member of the staff can ask Sarah is: "A couple of days ago you let the team know you were struggling to stay focused on yourself due to the multigenerational loss your family is going through. Are you able to focus more, the same, or less on yourself today?"

We encourage you to think of questions that might determine whether the third goal has been met.

Goals and Discharge Planning

It is important to emphatically state that chaplains, like the rest of the staff in hospital and rehabilitation facilities, should also tie their goals into discharge planning. Yes, we, as members of a larger health care team, are also involved in discharge planning! The work of helping a patient recover and leave the facility is good chaplaincy on our part. Further, it is good stewardship of limited resources if we help get a patient appropriately discharged without spending unneeded additional days in a health care setting. We know that the longer people stay in a health care facility like a hospital, the more likely they are to develop infections and other secondary health issues.

There are a variety of issues and situations for which professional chaplains are uniquely positioned to help someone leave the facility earlier rather than later. The authors of this chapter have all been actively, repeatedly, and on an ongoing basis involved in setting spiritual / pastoral goals directly related to discharge. The trigger may not come from our assessment, but it may come from another department's assessment. Integrating our care plan into the larger care plan not only allows us to have our notes seen by others, but equally, also allows for us to read other notes and be able to step in and provide needed resources.

Following are a few examples of how chaplains can and should be involved in goals related to discharge:

- A chaplain may discover that a patient is not fully participating in his rehabilitation because he believes that God is punishing him. He may believe that it is thus not proper for him to be free of pain and feeling better and that God will heal him when it is the right time. The chaplain may be able to reframe this belief to include the possibility that God wants and even expects us to participate in our own healing.
- A social work note may indicate that hospital discharge is being delayed because someone needs a ride home and then help into and within her house. If we know the person is active in a house of worship, the chaplain can often help facilitate, with the patient's permission, involving the health ministry / caring committee of the congregation to meet this discharge-specific need.

- A patient care coordinator note may indicate that a patient needs someone to stay with him for a couple of days after discharge but is unwilling to agree to "allow strangers in my home." Often these patients may be comfortable with members of their religious community staying with them. We can thus facilitate this spiritual process of connecting a congregant with his congregation.

Patients hospitalized for behavioral health issues often have their spiritual and religious resources overlooked by other departments when it comes to discharge planning. They are not the experts when it comes to networking and making connections with local houses of worship; we are. Houses of worship and leaders of faith communities are often overlooked as resources to help someone struggling with a behavioral health issue stay well and out of the hospital.[4] In our thinking about discharge planning, we can help document spiritual and religious tools a patient might possess to allow him or her to be discharged. Further, we can then become involved in helping the patient learn to use these resources.

Outcome oriented chaplaincy impels us to work smarter, for the good of the patients and their families, in the specific area of discharge planning. If not us, who? If not now, when?

Interventions

Day X: Recommend the following interventions for Sarah: (1) Chaplain explore with Sarah and her husband various spiritual tools from her tradition, such as ethical wills and other similar spiritual tools, that will allow her to guide and accompany her daughter in the years ahead. This might help in lowering her sense of being overwhelmed by guilt. (2) Recommend involvement of Dr. Ben Met of Consult Liaison Psychiatry. His expertise is multigenerational loss. He himself is the child of Holocaust survivors and has extensive experience in this field. His involvement might facilitate patient being able to be less distracted by her family's multigenerational needs around loss. (3) Chaplain will work to arrange a meeting of nurse managers and social workers of both this unit and PICU with patient to strategize on ways to allow her to be further involved in her daughter's care and be able to help provide comfort to her at this time.

Day Y [7 days after X]: (1) Over the last week chaplain explored with Sarah and her husband "ethical wills," a spiritual tool found in Judaism (patient's religion). Sarah is starting to make one now. She is also working with her husband to create a series of letters, pictures, and collages to be given to Rebecca, her daughter, at different points in her life that Sarah knows she will not be present for. These include bat mitzvah, sweet sixteen, loss of any grandparent, starting high school, various holy days in the years ahead, finishing high school, starting college, and finishing first semester of college. Sarah stated during our work together that these practical and concrete spiritual tools are helping her feel less overwhelmed by her guilt. (2) Followed up with Sarah after Dr. Ben Met's visit. She indicated that her parents, in particular, found speaking with him helpful and that they planned to continue meeting with him. Sarah articulated a deep sense of relief and felt it easier now (than when we previously spoke) to put the focus back on herself and her needs. (3) As indicated elsewhere in notes (see Social Work and Nursing), Sarah is working closely with staff from both this unit and PICU to find ways to comfort her daughter. She particularly found helpful the picture phone installed in both her room and her daughter's so she can watch, talk, and spend more time with Rebecca. Sarah's face lit up when she recounted how she was able to read to Rebecca from the same book that someone was holding for Rebecca. Her husband indicated that he has not seen Sarah this happy since she was admitted and profusely thanked the staff for the creative ways we have addressed Sarah's sadness.

Interventions should be based upon goals, either previously stated in a care plan or ones that will be included in the care plan after the visit (i.e., for first visits or in cases in which new issues were assessed during a visit and then treated). Further, interventions should relate and reference specific goals when put in writing.

Equally important, after a first visit, care plans should include proposed interventions based upon the assessment if subsequent visits are planned or needed. Future visits will most likely occur when patients are in intensive care units, have illnesses that bring them repeatedly back to a health care facility (such as cancer), are in a behavioral health facility (where the average length of stay is still longer than a day or two versus a medical facility), are in hospice, or are residents

of a long-term care facility (for reasoning on these assumptions see chapter 28). Then in subsequent visits, assuming that a chaplain sees a patient more than once, the care plan should document interventions provided and their outcomes. Our profession is moving toward outcome oriented chaplaincy. Our care plans, to be state of the art and current, need to incorporate this methodology within them.

Chaplains have a wide range of interventions at their disposal. Figure 5.2 lists just a few of the major areas. (See also chapter 27, Figure 27.1 for other interventions.)

A key part of outcome oriented chaplaincy, as it relates to interventions, is documenting our specific and detailed interventions and equally their outcomes—positive, negative, and none. Just as writing "spiritual distress" is no longer state of the art, neither is just documenting "pastoral visit with interventions." Writing "spiritual distress" is the equivalent of a nurse writing "sick" and does little to advance our shared understanding of the issues that need to be addressed. Our care plan intervention notes need to be detailed, clear, and concise. Further, they need to be ones that any member of the team can read and have an understanding of both the goal and the expected outcome of the intervention, whether successful or not.

With Sarah, the patient in this chapter's case, the first assessed spiritual issue was "being overwhelmed by guilt." The stated spiritual / pastoral goal was to "help her feel less overwhelmed." The proposed initial intervention as it related to this issue and goal was exploring spiritual tools directly related to the stated issue—"depriving her daughter of her time and her guidance." The intervention was about working with Sarah to help her gain a sense of control, the opposite of being overwhelmed. A specific outcome was desired and documented.

The follow-up chart note then went into detail about the intervention. It documented the intervention in plain English, so that any member of the team could understand. Understanding of the proposed / actual intervention is essential in a team environment. The chaplain has limited time (i.e., limited resources). The clarity of the note in the care plan allows other team members to become involved in the patient's spiritual care.

To reiterate, the chaplain has the expertise to make a detailed spiritual / pastoral assessment and set up specific goals. We are the subject-matter experts and thus oversee the spiritual care. However, in a team environment, others may help implement the goal—depending on the situation.

EXAMPLES OF SPIRITUAL / PASTORAL INTERVENTIONS

Exploring and developing spiritual coping resources

Helping patients examine / explore the following from a spiritual perspective:
- Abandonment
- Anger
- Confession
- Courage
- Depression as a spiritual illness
- Emptiness
- Forgiveness
- Guilt
- Hope
- Hopelessness
- How spirituality helps in healing
- Living with chronic illness
- Loneliness
- Meaning
- Meaninglessness
- Meditation
- Negative religious experiences
- Prayer
- Repentance
- Salvation / redemption
- Sin
- Suicide / sanctity of life
- Respect / self-respect
- Ritual(s)

Helping patients examine their image of God and increase their spiritual understanding of that image in relationship to:
- Coping with chronic illness
- Hope
- Their attitudes
- Their behavior
- Their purpose

Helping patients examine their spiritual belief system, including:
- "Beneficial" nature of core religious / spiritual beliefs
- Benefits of individual beliefs
- Congruence of core religious / spiritual beliefs
- Non-"beneficial" nature of core religious / spiritual beliefs
- Reality of beliefs versus symptomalogy of illness
- Role of God / Higher Power in recovery process
- Role of spirituality / spiritual tools in recovery
- Supporting and / or developing religious coping resources

Patients' Pastoral and Spiritual Resources
- Active in religious community
- Active prayer life
- Active religious home life

Figure 5.2

With Sarah, the nurses, nurses' aides, doctors, social workers, dietitians, and food service workers could all ask her and her husband about the progress of her projects, thus giving her more of a sense of control and also encouraging her to continue. Equally important is that other team members can sit with the patient and have her talk about the different components of the work she is doing, thus involving the full team in the spiritual / pastoral care plan. Other team members can then also document their involvement and any outcomes they observe that may occur when the chaplain is not present—such as feeling less overwhelmed by her sense of guilt.

Referrals are a key part of the job of a professional chaplain. Knowing when and to whom to refer—both in general and also in a specific facility—should always be part of our ongoing professional development. The care plan in this chapter documented the need for a referral, the goals for a referral, and finally the outcomes from the referral.

We encourage you on your own or as part of a group process to review and discuss / reflect on Sarah's third spiritual issue, the goals related to it, the proposed intervention, and then the documented actual intervention and outcome.

Electronic Medical Record and Care Plans

Electronic medical records (EMRs) are the new state of the art. Soon all charts will be in this format. EMRs offer some clear advantages over paper charting as they relate to documenting assessed issues. At the same time, they bring their own challenges.

Some of the positives of the EMR as they relate to care plans include the following:

- The work of drafting the chaplaincy section of the EMR will help organize the chaplain's work. The chaplaincy section of the EMR should be more than just boxes in which professional chaplains, chaplaincy residents, and clinical pastoral education (CPE) students check off issues they have observed, suggested interventions, and goals they seek. Check boxes may work in many cases (particularly with CPE students and others just learning our field), but the writers of this chapter strongly feel that it also needs to

include sections for free-form writing of the details of our care plan for more complete and / or complicated cases. Further, these text boxes help prevent us from moving from "patient-centered care" to "chart-centered care."

- In designing the chaplaincy / spiritual / pastoral care department section of the EMR, those in the department will be obligated to clearly articulate to both those designing and those approving the EMR system the spiritual / pastoral issues they assess, interventions they provide, and goals they seek to accomplish in that particular institution. This clarity then carries over in allowing chaplains to clearly explain and document the work they do, through the EMR, to those they engage with on a daily basis.
- The EMR, if set up properly and with forethought, should help chaplains systematically reflect upon the work we do. Reflection upon the work we do is something we learn as CPE students using verbatims. EMRs can help us keep this skill current and focused.
- Having a chaplaincy section fully integrated into the EMR should help improve communications and interactions between chaplaincy departments and others within the institution.
- Consistency in charting leads to increased accountability as well as increased professional respect and recognition by our coworkers.
- In departments that train in the field of chaplaincy, a well-designed EMR helps those new to the field better understand the role and function they should be seeking to grow into.
- Ultimately, a good EMR departmental section will help each member become more of an effective, outcome oriented professional chaplain.

Some of the "growing edges" of the EMR as they relate to a care plan include the following:

- The challenge of looking at each patient / resident as a unique individual with his or her own distinctive life

history rather than just a number that needs to have boxes checked off.

- Time to effectively complete a personalized care plan rather than just using the check boxes to get done quickly.
- Working with management to get the EMR updated as the department changes and its needs and focus of work change.

Religious Needs

Religious needs are not the same as spiritual / pastoral needs. A patient, resident, or family member might have no need for spiritual / pastoral care and yet have high religious needs. The system set up in your institution should be able to separate the two, particularly at the screening stage. A professional chaplain often does not need to provide the religious items, particularly when there is limited staff and high needs. However, the department is always responsible for making sure they are available and provided in a timely fashion. Also, these needs should be documented in the chaplain's chart note so that staff are aware of what the patient's religious practices are. For example, the chart note could say, "Patient prays three times a day around X times" or "Patient eats only kosher food and may therefore be concerned about by-products that could be in medication."

Religious needs include the following:

- Food according to certain religious standards (e.g., halal or kosher)
- Religious items (e.g., sacred scripture, prayer books, rosaries, electric candles for the Sabbath, prayer rugs)
- Access to religious worship (e.g., daily in some traditions; weekly—Friday, Saturday, or Sunday depending on tradition; holy day services)
- Access to sacraments. The most common sacrament needed in the United States at the current time is the Eucharist. It is important to make sure that the chart properly reflects the person's religion, because there is a difference among Protestant, Roman Catholic, and Orthodox traditions as

to who may receive the sacrament from their tradition. Other sacraments often requested are anointing and prayers for healing.

Notes

1. Standard 2 of Association of Professional Chaplains, *Standards of Practice for Professional Chaplains in Acute Care Settings*, www.professionalchaplains.org/uploadedFiles/pdf/Standards%20of%20Practice%20Draft%20Document%2002 1109.pdf#Project_Update.
2. G. Handzo and H. Koenig, "Spiritual Care: Whose Job Is It Anyway?" *Southern Medical Journal* 97, no. 12 (December 2004): 1242–44.
3. K. Zygowiec, "Asking for a Prayer—Without Asking," *PlainViews* 8, no. 6 (April 20, 2011).
4. Glen Milstein et al., "Implementation of a Program to Improve the Continuity of Mental Health Care through Clergy Outreach and Professional Engagement (C.O.P.E.)," *Professional Psychology: Research and Practice* 39, no. 2 (2008): 218–28.

Further Reading

Fitchett, George, and James Risk. "Screening for Spiritual Struggle." *Journal of Pastoral Care and Counseling* 62, nos. 1–2 (2009): 1–12.

Puchalski, C., and B. Ferrell. *Making Health Care Whole: Integrating Spirituality into Patient Care*. West Conshohocken, PA: Templeton Press, 2010.

About the Contributors

Rabbi Stephen B. Roberts, MBA, MHL, BCJC, is the editor of this book and coeditor of *Disaster Spiritual Care: Practical Clergy Response to Community, Regional and National Tragedy* (SkyLight Paths Publishing). He is a past president of the National Association of Jewish Chaplains. Most recently he served as the associate executive vice president of the New York Board of Rabbis, directing their chaplaincy program, providing services in more than fifty locations throughout New York, plus serving as the endorser for both New York State's and New York City's Jewish chaplains. Prior to this he served as the director of chaplaincy of the Beth Israel Medical System (New York), overseeing chaplains and CPE programs at three acute care hospitals, one behavioral health hospital, plus various outpatient facilities served by chaplains.

Chaplain D. W. Donovan, MA, MS, BCC, currently serves as the mission leader at Providence Holy Cross Medical Center in Mission Hills, California. Board certified since 2001, Donovan has served in hospital chaplaincy since 1997. He served as chief resident of the Pastoral Care Department at the Medical College of Virginia and as the manager of pastoral care at Bon Secours Richmond Health System. Donovan served as committee secretary and general editor in the writing of the *Common Standards for the Certification and Practice of Chaplaincy* and served as the first lead interview team educator with the National Association of Catholic Chaplains (NACC). Highly involved with medical ethics, he is the author of "Defending the Donor's Decision: An Analysis of the Ethical Issues Related to First-Person Declarations of Organ Donation," published in *Health Progress*. He consults on a range of issues related to pastoral care, medical ethics, and liturgy.

Rev. George Handzo, MDiv, BCC, CSSBB, is the vice president of Chaplaincy Care Leadership and Practice at HealthCare Chaplaincy. Rev. Handzo directs the only consulting service devoted to the strategic assessment, planning, and management of chaplaincy services. HealthCare Chaplaincy employs best practices in strategic planning and clinical practice to maximize the effectiveness of an organization's pastoral care and to align it with the institution's overall objectives. Prior to his current position, Rev. Handzo was the director of Chaplaincy Services at Memorial Sloan-Kettering Cancer Center for more than twenty years and is a past president of the Association of Professional Chaplains. He serves on the Distress Guidelines Panel of the National Comprehensive Cancer Network. Rev. Handzo has authored or coauthored more than fifty chapters and articles on the practice of pastoral care.