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Communicating Spiritual Care in the Electronic Health Record

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Chaplains must document their ministry of care in electronic health records that primarily focus on the physical dimension of care. Creating chaplain documentation that reflects the spiritual dimension of care requires chaplains to participate in the screen design. This article describes how chaplain documentation was designed and refined using psychometric methods. The resulting system successfully supported chaplain workflow, provided an ability to aggregate chaplain workload, and integrated the chaplain into the interprofessional team by structuring, linking, and sharing both the chaplain and nursing assessment of spiritual distress in the electronic health record. Documentation used 5-point Likert scales to measure different dimensions of patient spirituality. Reliability and validity were further evaluated as part of a workshop at an Association of Professional Chaplains annual meeting. Findings supported interrater reliability and the ability to predict and discriminate change pre and post encounter. Documentation screen content is presented.

KEY WORDS: Chaplain, Electronic health record, NOC, Nursing, Spiritual care

The electronic health record (EHR) is designed to facilitate communication among healthcare providers at the moment of patient need. Although EHRs are designed to communicate physical, psychological, and social health information, little has been done to integrate spiritual assessments or spiritual care beyond the admission assessment of faith traditions.[1] Integrating spiritual information into the EHR across healthcare professionals has the potential to communicate patient spiritual needs and facilitate spiritual care to better meet patient needs, particularly during times of spiritual distress.

Over the last several decades, research has demonstrated that patients have rising interest in spirituality[2] and want and need spiritual care.[3–6] Spirituality is the expression of meaning and purpose in life through connectedness with self, others, or a higher power that may or may not include religious dimensions.[7] Nurses hold an important role and professional obligation to provide spiritual care, as they are at the bedside 24 hours a day, 7 days a week.[8–12]

Chaplains provide expertise in spiritual care and recognize the professional requirement to document their care, primarily using free text to share the depth of the story.[13,14] Several different documentation models have emerged to capture chaplain documentation,[15,16] as well as methods to document spirituality within medicine and nursing.[12,17] These methods structure narrative assessments into categories and provide some spiritual assessment data, but they require qualitative analysis to aggregate data in a meaningful way to facilitate collaboration, provide summary reports to guide staffing, or measure the effect of spiritual care on patient outcomes.[18] This type of documentation can limit timely sharing of important information among the healthcare team.[19,20]

Although The Joint Commission requires access to religious and spiritual services (RI.01.01.01) and the provision of spiritual care at end of life (PC.02.02.13) within a multidisciplinary environment, this is operationalized differently at other institutions with varying degrees of integration.[21,22] Many institutions meet this requirement by including religious/spiritual practice assessment questions as part of the admission assessment procedures and initiate a chaplain referral as requested. In this model, it is unclear how much or whether spiritual care information is shared among team members.[23] Many healthcare providers, including nurses, physicians, and social workers, recognize the importance of spiritual care and have developed models to integrate spiritual care within their discipline and practice.[8–10,24,25] However, research has shown that many healthcare professionals are uncomfortable assessing for spiritual needs and providing spiritual care and require additional guidance in integrating spiritual care based on patient need.[11,26,27] Choi et al[1] have also found that chaplains are not incorporated within

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the interprofessional team and are primarily contacted at end of life. A structured communication mechanism to share spiritual information among the interprofessional team using the EHR can facilitate and support the provision of spiritual care.

INTEGRATING CHAPLAIN AND NURSE DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD

An integrated spiritual care documentation model was developed as part of the Loyola Medicine adoption of the Epic EHR documentation system (Epic Systems Corporation, Madison, WI). The previous EHR only indicated religious affiliation upon admission and in chaplain documentation, including tabulating the type of chaplain clinical encounter (routine, continued, surgical), religious sacraments provided (communion, baptism, anointing of the sick), and cultural needs. There was no spiritual care documentation in the nursing flow sheets. Because spiritual care was integral to the health system's mission, integrating spiritual care documentation was valued by the organization. The Spiritual Care Department took primary responsibility to identify how best to capture spiritual care, beginning with chaplain documentation. The Steering Committee for Nursing Documentation took primary responsibility to design nursing flow sheets. Both groups collaborated to determine how best to communicate spiritual needs in the Epic documentation system. This led to a detailed chaplain documentation flow sheet with a common row consisting of a global measure for spirituality to asynchronously communicate spiritual needs between chaplains and nurses.

Chaplains were charged with designing the content and structure of the day-to-day chaplain documentation in a flow sheet format, in which rows are assessment and intervention categories, and columns indicate the date and time of the encounter. The goal of this redesign was to more holistically capture spiritual care beyond the type of clinical encounter, provision of religious sacraments, and identify cultural need. It needed to support chaplain workflow, provide a decision support system to communicate patient spiritual care needs to nurses asynchronously, and offer a method to produce summary reports to describe patient spiritual needs and chaplain workflow. The redesign required a methodical team approach and was grounded in chaplain day-to-day practice. This article describes how the system was developed, validated, and evaluated in three phases.

PHASE 1: PREREDESIGN CHAPLAIN WORKFLOW

The Spiritual Care Department created a task force to evaluate the initial chaplain documentation screens and guide the redesign. Members of the task force included five chaplains and one nurse researcher with expertise in standardized terminology and spiritual care documentation. The first step in the redesign was to evaluate the initial documentation screens and map chaplain workflow. The task force agreed that the previous documentation lacked clarity and specificity to reflect chaplain care. The task force developed workflow designs to identify the different components of chaplain day-to-day activities. This evaluation revealed four types of care categories: encounter logistical information, religious care, culture care, and spiritual care.

PHASE 2: THE REDESIGN

The initial documentation system included some logistical information and religious and culture care categories, but lacked spiritual care concepts. The team mapped the existing system into the workflow to identify points of congruence, lack of clarity, and gaps. Logistical information, religious care, and culture needs documentation were refined, but spiritual care concepts were needed to better reflect and communicate the nature of the ministry. The workgroup initially identified spiritual care concepts from the Nursing Outcomes Classification (NOC), which is a taxonomy of nursing-sensitive patient outcomes measured on a 5-point Likert scale, with 1 as the worst measure and 5 as the best measure.[12,28] For example, *hope* could be measured numerically as 1 for not demonstrated or 5 as consistently demonstrated.[28]

Psychometric research for NOC was conducted with parish nurses, which supported the reliability and validity of several spiritual NOC labels.[12,29] The workgroup identified an initial list of outcome labels from the NOC taxonomy using consensus opinion. Definitions of the labels were reviewed, and some were refined to better reflect chaplain care. The outcome lists with definitions were evaluated by five board-certified chaplains to evaluate conceptual relevance and application to practice. Concepts with high relevance were included in the pilot screen designs. A paper-and-pencil version of the spiritual care documentation screen and time spent during the encounter was piloted for 1 month with five chaplains. Frequency of item use was tabulated, and items that were not used were eliminated from the list. A focus group of the five practicing chaplains was held to discuss usability, understandability, and utility, as well as total time and workload for documentation. The final documentation item list was refined based on the pilot findings. The final list of documentation items and numeric drop-down options were programmed into Epic to pilot the system, as shown in Table 1.

Further Refinement: Adding Outcome Change Score

A goal of the documentation refinement process was to integrate a strategy to measure the effect of chaplain care within the encounter on patient spiritual needs. Therefore, the documentation included an opportunity to measure patient spiritual concepts before and after chaplain encounter. For example, if a chaplain visited a patient preoperatively with a possible cancer diagnosis pending surgery, the chaplain

Table 1. Chaplain Documentation Rows and Drop-Down Options in Epic

Row Title	Drop-Down Options Per Column
Clinical encounter information	
Visited with	Patient, family, patient, and family together, patient not available, health care provider, sitter, consult another chaplain
Routine visit	Introduction, follow-up, follow-up palliative care, discharge, patient requests no PC
Continue visiting	Yes, no
Surgical visit	Preoperative, surgery canceled, surgery not imminent, in surgery, postoperative
Patient wants PC visit preoperatively	Yes, no, completed
Crisis visit	Emergency room, trauma, critical care, patient actively dying, death, code blue, code respiratory, code stroke, rapid response,
Referral from	Epic—completed, pager 1, pager 2, phone, patient, family, chaplain, nurse, unit secretary, physician, social worker, case manager, physical therapy/occupational therapy, speech, nutrition, housekeeping, other
Referral to	Chaplain, nurse, physician, social worker, music practitioner, other
Consult	Patient care, formal ethics consult, ethical conversation, palliative care
Religious needs	Prayer, PC brochure, Bible, literature, religious articles, comfort care blanket, comfort care cart
Priest requested	Patient requested priest visit, priest visited
Sacramental encounters	
Communion desired	Ask, daily, no, Sunday only, unable to receive, offered—not received
Communion given	Yes, no, family
Sacrament of Sick/anointing	Anointed, patient requested anointing, patient requested priest visit family requested anointing, chaplain requests anointing/priest assesses, visiting priest anointed patient, patient not available for requested anointing, patient declined anointing, chaplain offered/patient declined, chaplain offered, family declined
Baptism	Baptized, family requested baptism, patient not available for requested baptism, declined offered baptism
Other	Confirmation, marriage
Cultural encounters	
Cultural needs	Translation services: interpreter, translation services: phone, translation services: family assist with spiritual care, translation services: healthcare worker assist with spiritual care, attitudes to illness & hospitalization, traditions & beliefs (e.g., privacy, touch, space, time), dietary needs, family dynamics/ roles/structures, communication patterns & styles, at death: explicit discussion with family regarding cultural/religious needs
Patient spiritual encounters using NOC outcomes and scales	
Spiritual assessment[a]	Demonstration scale (1–5, unable to assess)
Child adaptation to hospital	Demonstration scale (1–5, unable to assess)
Suffering severity	Severity scale (1–5, unable to assess)
Fear level	Severity scale (1–5, unable to assess)
Anxiety level	Severity scale (1–5, unable to assess)
Loneliness severity	Severity scale (1–5, unable to assess)
Hope	Demonstration scale (1–5, unable to assess)
Coping	Demonstration scale (1–5, unable to assess)
Social interaction skills	Demonstration scale (1–5, unable to assess)
Grief resolution	Demonstration scale (1–5, unable to assess)
Dignified life closure	Demonstration scale (1–5, unable to assess)
Family coping	Demonstration scale (1–5, unable to assess)
Family participation professional care	Demonstration scale (1–5, unable to assess)
Family support during treatment	Demonstration scale (1–5, unable to assess)
Caregiver-patient relationship	Positive scale (1–5, unable to assess)

[a]Later changed to spiritual distress.

Abbreviation: PC, pastoral care/spiritual care.

may document "fear" as 2 and "hope" as 2 at the beginning of the encounter and 3 and 4, respectively, at the end of the encounter. This can be interpreted as the patient feeling fearful of the diagnosis with little hope but experiencing less fear and more hope by the end of the encounter. In this way, the chaplain's choice of concept indicated the relevant

spiritual issue, and the change in measurement indicated the effect of the spiritual intervention during the hospitalization.

Documentation to Facilitate Clinical Decision Support

Spiritual needs occur in the moment and require rapid communication and follow-up. Therefore, it was important that spiritual care information be shared with the interprofessional team quickly when patients experience the need. An interprofessional clinical decision support communication mechanism integrated in the EHR can automate a referral system to immediately notify the most appropriate care provider to meet patient spiritual need.

Providing spiritual care is considered a dimension of professional nursing practice.[8–10] Nurses frequently contact chaplains for patients' complex spiritual needs, but the referral and access to the chaplain take time. Therefore, in the Epic design, both chaplains and nurses collaborated in creating a common field between the two documentation flow sheets for the global Spiritual Assessment. As a common field (appearing as a row in Epic), both chaplains and nurses see each other's documentation for this one field as part of their day-to-day documentation screens. This provides asynchronous communication as a "red flag" for chaplains and expert spiritual assessment and follow-up data for the nurses. This system also became an automated clinical decision support in that if a nurse documented a 1 or 2 in the Spiritual Assessment row, that entry automatically triggered a chaplain referral. Those referrals generated a list of patients for chaplains to see each day.

The automatic chaplain consult functionality was also initiated as part of physician order sets, including transplants, organ donation, abdominal aortic surgery, and end-of-life and palliative care. Chaplains also assessed all preoperative patients and patients in the palliative care service. The Spiritual Care Department received a list of all new admissions, with priority given to patients with a length of stay greater than 3 days. These automated and systematic referral systems intentionally created a mechanism to identify individuals with high spiritual needs.

In addition to the flow sheets, chaplains completed a progress note, transferring the flow sheet content into a note with the ability to add focused narrative documentation as needed for a subset of patients: referrals, death or actively dying, change of condition, trauma, and intensive care unit visit. These notes provided a mechanism to communicate more detailed chaplain care within the interprofessional team. This was a key strength of the pilot revisions to the EHR.

PHASE 3: EVALUATING DOCUMENTATION RELIABILITY AND VALIDITY

In addition to content and face validity testing during the chaplain flow sheet screen design phase, the chaplain task force was invited to share this system at an Association of Professional Chaplains national conference. The team chose to use a 90-minute workshop to both describe the chaplain documentation system and ask chaplain participants to test the system. This not only provided a strategy to present the system in a didactic format, but also allowed chaplains to experience the system using case studies. Chaplains were invited to participate in a study to evaluate the documentation system if they chose to share their data from the workshop. Institution review board approval was obtained by the health system.

Design

This was a descriptive study in which participants documented the care provided after viewing and reading three vignettes designed to reflect a change in patient spiritual outcomes after chaplains provided spiritual care. Vignette 1 described a 19-year-old man with a gunshot who was admitted to the emergency department, preoperative for an emergency femoral artery repair. Vignette 2 described an 84-year-old White, Roman Catholic woman admitted for a planned open-heart surgery, and the chaplain visited the patient during a routine preoperative patient visit. The patient needed to confess an affair from 50 years previously. Vignette 3 involved a 30-year-old Black, Baptist woman and single mother of two with stage 4 breast cancer. The patient's parents and children were in the room.

Instrumentation

The three vignettes were developed by professional chaplains and were designed to reflect typical care situations in an acute care setting. In each vignette, chaplain care was designed to improve spiritual indicators. The vignettes were evaluated by five board-certified chaplains external to the health system. The content reviewers evaluated appropriateness of the script and whether the script reflected a spiritual care encounter and measured the patient's spiritual indicators at the beginning and end of the encounter. All content experts agreed that the three scripts appropriately reflected a spiritual care encounter. All spiritual indicators chosen demonstrated a positive change in spirituality from the beginning to end of the encounter. This supports the vignettes' content validity.

Sample

Chaplains interested in learning about chaplain documentation signed up for this workshop (75 participants). After the didactic portion, all participants were invited to participate in documentation exercise as part of the workshop. The study was described, and the participants were invited to participate in the study by submitting their anonymous survey data to the presenters at the end of the workshop. All participated in the exercise, as this was a learning experience.

Table 2. Respondent Characteristics

	No. Reported	Overall n = 68
Age, mean (SD)	67	54.6 (11.1)
Female, n (%)	65	19 (29.2)
Race, n (%)		
White	59	55 (93.2)
African American		2 (3.4)
Other		2 (3.4)
Credentialing,[a] n (%)		
Board-certified chaplain	66	58 (87.9)
National Board for Certified Counselors		4 (6.1)
Student		2 (3.0)
Other		5 (7.6)

[a]May select more than one response.

Submitting the data collection forms was not required to participate in the exercise.

Data Collection

All workshop participants received a copy of each vignette script and two surveys per vignette listing the spiritual indicators on 5-point Likert scales, along with the definition of each spiritual indicator. All workshop attendees were invited to participate in the exercise and could voluntarily share their data at the end of the workshop. Each vignette was acted out by the workshop presenters. Participants were directed to choose what spiritual indicators were relevant to the vignette and measure the patient's spirituality at the beginning and end of the encounter.

Statistical Analysis

Participant characteristics were presented as means and SDs or counts and percentages. For each vignette, the median value, the percentage at the median value, and the percentage within

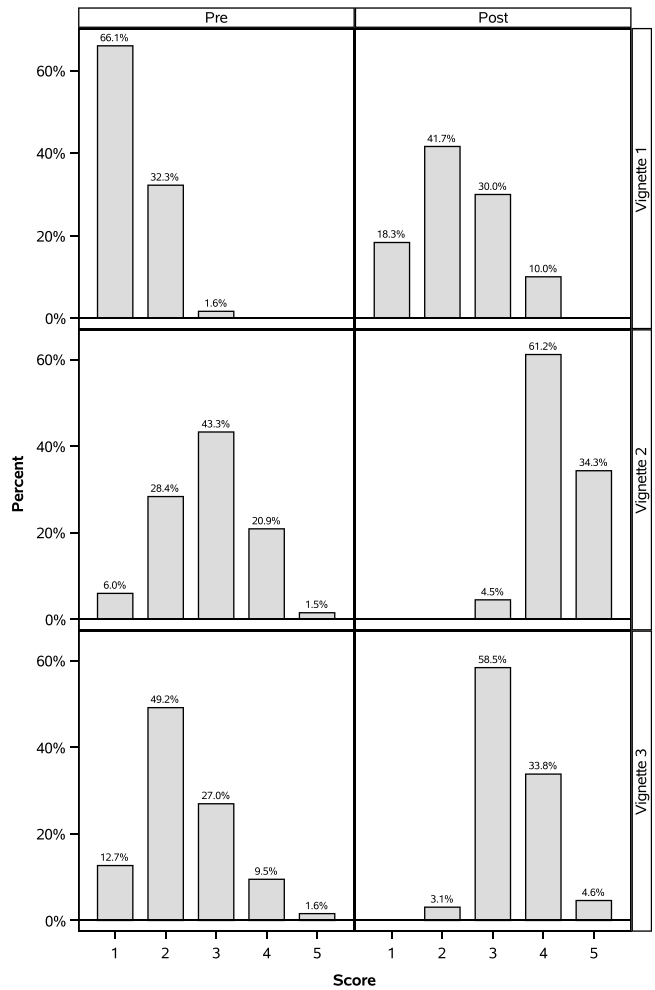

FIGURE 1. Histograms of chaplain responses to spiritual assessment for vignettes 1 to 3.

Table 3. Chaplain Responses at the Beginning and Conclusion of Patient-Chaplain Vignettes for Each NOC Outcome

	Vignette 1						Vignette 2						Vignette 3					
	Pre			Post			Pre			Post			Pre			Post		
	n	Median Value (%)	% Within 1 Point of Median	n	Median Value (%)	% Within 1 Point of Median	n	Median Value (%)	% Within 1 Point of Median	n	Median Value (%)	% Within 1 Point of Median	n	Median Value (%)	% Within 1 Point of Median	n	Median Value (%)	% Within 1 Point of Median
Spiritual assessment	62	1 (66.1)	98.4	60	2 (41.7)	90.0	67	3 (43.3)	92.5	67	4 (61.2)	100.0	63	2 (49.2)	88.9	65	3 (58.5)	95.4
Suffering severity	63	1 (54.0)	98.4	59	2 (39.0)	98.3	67	2 (38.8)	86.6	67	4 (64.2)	97.0	65	2 (67.7)	100.0	65	3 (66.2)	100.0
Fear level	63	1 (69.8)	100.0	59	3 (57.6)	86.4	68	3 (25.0)	86.8	67	4 (56.7)	97.0	65	2 (63.1)	98.5	64	3 (57.8)	96.9
Loneliness severity	63	2 (54.0)	90.5	59	3 (52.5)	96.6	65	3 (33.8)	83.1	66	4 (48.5)	100.0	65	3 (35.4)	86.2	65	4 (43.1)	96.9
Hope	62	2 (53.2)	95.2	60	3 (60.0)	91.7	65	3 (56.9)	90.8	68	4 (52.9)	100.0	65	3 (55.4)	96.9	65	4 (44.6)	100.0
Coping	63	2 (55.6)	95.2	60	3 (63.3)	98.3	67	3 (52.2)	91.0	68	4 (54.4)	100.0	65	3 (61.5)	98.5	65	3 (49.2)	92.3
Social interaction skills	61	2 (42.6)	91.8	58	3 (58.6)	94.8	64	4 (46.9)	93.8	64	5 (56.3)	85.9	63	4 (49.2)	96.8	64	4 (51.6)	96.9
Grief resolution	55	2 (49.1)	96.4	53	3 (47.2)	88.7	52	3 (36.5)	88.5	49	4 (53.1)	100.0	56	3 (58.9)	98.2	54	3 (51.9)	96.3
Family coping													64	3 (45.3)	90.6	63	4 (42.9)	98.4
Family normalization													63	4 (42.9)	88.9	62	4 (46.8)	95.2
Family participation													57	4 (36.8)	86.0	58	4 (46.6)	96.6
Family support													63	4 (54.0)	96.8	63	5 (50.8)	93.7
Caregiver patient relationships													63	4 (44.4)	93.7	63	5 (55.6)	90.5

one point of the median were calculated at the beginning and conclusion of the vignette to describe the central tendency and spread for each spiritual indicator. The percent noting improvement at the conclusion of the spiritual intervention was determined by increases of ≥1 point from the score at the beginning of the vignette. The statistical significance of differences in prevignette to postvignette scores was assessed with Wilcoxon signed rank tests. Analyses were performed in SAS version 9.4 (SAS Institute, Cary, NC).

Findings

Sixty-eight chaplains completed surveys and were included in this study. The majority of participants in the study were men (71%), middle-aged (55 years old), and White (93%), as shown in Table 2. Each spiritual indicator was evaluated using a histogram, indicating nonnormality with kurtosis around the medians. For example, Figure 1 presents the pre- and post-encounter histograms for the Spiritual Assessment global indicator for each vignette, graphically demonstrating that the median, or the most common value, positively increased before and after encounter. Table 3 presents the results for each outcome indicator per vignette, including the number of chaplains who chose that indicator, the median value at the beginning of the encounter, the percent of chaplain who chose that median value +/− one point, as well as the same statistics at the end of the encounter. Table 4 includes the change score (post-encounter minus pre-encounter) and whether the change in value was statistically significant. For vignette 1, the median spiritual indicator values were 1 or 2, with greater than 90% within one point of the median on all items at the beginning of the encounter (Table 3). At the end of the encounter, the median spiritual indicator values were 2 or 3, with greater than 85% agreement on the items. All items across all vignettes demonstrated a statistically significant positive change. Vignette 3 was a more complex family encounter, with spiritual indicator values 2 to 4 at the beginning of the encounter and 3 to 5 at the end of the encounter, but all spiritual care indicators demonstrated a statistically significant improvement (Table 4).

As shown in Figure 1, median values at the anchors (1 or 5) were more kurtotic and demonstrated higher agreement, whereas median values of 2 or 3 were more symmetrically distributed, demonstrating greater variability. This indicates that interrater agreement is strongest in scenarios that reflect severe spiritual distress or positive spiritual well-being, but agreement may be limited in more ambiguous scenarios. However, the changes in pre- and post-encounter values were significant in each vignette, supporting the ability of spiritual scales to discriminate the expected change within rater.

CONCLUSION

Following a methodical process of planning an EHR documentation redesign begins with engaging those who will use the system. The planning process included evaluating current chaplain

Table 4. Change in Responses Following Encounter

	% Increased[a]	Median Change (IQR)[b]	*P*[c]	% Increased[a]	Median Change (IQR)[b]	*P*[c]	% Increased[a]	Median Change (IQR)[b]	*P*[c]
	Vignette 1			Vignette 2			Vignette 3		
Spiritual assessment	71.7	1 (0, 1)	<0.001	89.4	1 (1, 2)	<0.001	77.8	1 (1, 1)	<0.001
Suffering severity	72.9	1 (0, 1)	<0.001	86.6	2 (1, 2)	<0.001	83.1	1 (1, 1)	<0.001
Fear level	79.7	1 (1, 2)	<0.001	79.1	1 (1, 2)	<0.001	81.3	1 (1, 2)	<0.001
Loneliness severity	64.4	1 (0, 1)	<0.001	71.9	1 (0, 2)	<0.001	41.5	0 (0, 1)	<0.001
Hope	66.1	1 (0, 1)	<0.001	83.1	1 (1, 2)	<0.001	64.6	1 (0, 1)	<0.001
Coping	73.3	1 (0, 1)	<0.001	76.1	1 (1, 2)	<0.001	56.9	1 (0, 1)	<0.001
Social interaction skills	41.1	0 (0, 1)	0.007	42.2	0 (0, 1)	0.002	31.7	0 (0, 1)	0.006
Grief Resolution	64.7	1 (0, 1)	<0.001	79.1	1 (1, 2)	<0.001	55.6	1 (0, 1)	<0.001
Family coping							60.3	1 (0, 1)	<0.001
Family normalization							45.2	0 (0, 1)	<0.001
Family participation							30.4	0 (0, 1)	<0.001
Family support							38.7	0 (0, 1)	<0.001
Caregiver patient relationships							34.4	0 (0, 1)	0.001

Abbreviation: IQR, interquartile range.

[a]Increased ≥ 1 point from beginning score.

[b]Post score minus pre score.

[c]*P* values from Wilcoxon signed rank test for change scores.

workflow, identifying key variables, engaging stakeholders in screen development, and testing the reliability and validity of the measurement system among chaplains. The documentation screens have been used in practice with minimal change, supporting the strength of this design strategy.

An adaptation of nursing standardized terminology supported chaplain spiritual care documentation and successfully communicated spiritual information to nurses. The documentation system can facilitate chaplain workflow in that it requires minimal time to complete at the point of care (a few minutes per patient), and the clinical decision support identified patients with spiritual needs, communicated that information to nurses, and generated a report to guide chaplain workflow. In practice, chaplains begin their workday as a team reviewing the list of patients with spiritual needs and assign a chaplain to visit those patients. That ongoing list of patients is followed as needed throughout their hospitalization. The system can also be used to generate monthly reports that describe the number of chaplain visits, time spent, and type of care provided. This documentation redesign integrated spiritual information in patient care and provided timely, asynchronous communication between chaplains and nurses to promote holistic care.

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